

103
**ADMINISTRATION OF THE MEDICARE PROGRAM—
PAYMENT SAFEGUARDS**

Y 4. AP 6/2: M 46/2

Administration of the Medicare Prog...

HEARING
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED THIRD CONGRESS
FIRST SESSION
SPECIAL HEARING

Printed for the use of the Committee on Appropriations



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ADMINISTRATION OF THE MEDICARE PROGRAM—PAYMENT SAFEGUARDS

FRIDAY, NOVEMBER 12, 1993

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:05 a.m., in room SD-192, Dirksen
Senate Office Building, Hon. Tom Harkin (chairman) presiding.
Present: Senator Harkin.

GENERAL ACCOUNTING OFFICE

HEALTH CARE FINANCING AND POLICY

STATEMENT OF SARAH F. JAGGAR, DIRECTOR OF HEALTH CARE FI-
NANCING AND POLICY ISSUES

ACCOMPANIED BY THOMAS DOWDAL, ASSISTANT DIRECTOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL

ACCOMPANIED BY GEORGE M. REEB, ASSISTANT INSPECTOR GEN-
ERAL FOR HEALTH CARE FINANCING AND AUDITS

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF CAROL WALTON, DIRECTOR, BUREAU OF PROGRAM
OPERATIONS

ACCOMPANIED BY:

CHUCK BOOTH, DIRECTOR, OFFICE OF PAYMENT POLICY, HCFA
LINDA RUIZ, ACTING DIRECTOR, MEDICARE BENEFITS ADMINIS-
TRATION

OPENING REMARKS OF SENATOR HARKIN

Senator HARKIN. Good morning. The subcommittee will come to
order. Today's hearing will review the current status of Medicare's
payment safeguard activities and examine recent reports of waste
and abuse in the Medicare system.

This hearing is part of a series of hearings the subcommittee has
held since I became chairman in 1989. The first hearing I con-
ducted was an oversight of Medicare contractors' payments safe-

guard activities. We examined fraudulent schemes which have since been largely brought under control. Subsequent hearings looked at losses Medicare incurred through failure to identify and bill other primary insurers.

We learned how hospitals overbilled Medicare and then kept for themselves large credit balances owed to Medicare until vigorous efforts were initiated to recover the money. We learned about some hospital schemes to inflate their reimbursement by manipulating billing codes. One of the most common types of fraud involves filing false claims in order to obtain payments to which providers are not entitled.

Unfortunately, as soon as some schemes are thwarted, new schemes crop up to take their place. This summer we uncovered excessive profiteering involving such items as hospital beds, glucose monitors, intraocular lenses, and so-called body jackets which would result in about \$1.2 billion in excessive payments over the next 5 years.

Why all these schemes? Well, it is simple. Medicare has become big business; 10 years ago, Medicare expenditures were \$83 billion. This year, Medicare spending exceeded \$150 billion. By the year 2000, spending will double to an estimated \$307 billion, and if nothing is done, 10 years from now Medicare spending will grow to over \$400 billion a year. As Medicare costs grow, so does waste and abuse, and I might add parenthetically, so do the number of people who want to get their fingers in the till.

The General Accounting Office has estimated that as much as 10 percent of health spending is lost through waste, fraud, and abuse. That is where payment safeguards come in.

This year, we appropriated \$389 million for the audit and review by Medicare contractors for claims payments. This work resulted in an estimated Medicare savings of \$5.6 billion, \$14 saved for every \$1 spent.

Medicare payment safeguards—fiscal years 1989–94

	<i>In millions</i>
1989:	
Investments	\$358
Savings	4,043
1990:	
Investments	345
Savings	5,315
1991:	
Investments	353
Savings	5,757
1992:	
Investments	349
Savings	5,246
1993:	
Investments	413
Savings	6,572
1994:	
Investments	389
Savings	5,609

Despite the fact that we know a greater investment in payment safeguards will return far greater overall savings to the taxpayers,

appropriations have not kept pace with the double digit growth in claims volume and benefit payments.

Just to meet the President's request for payment safeguards and Medicare contractors has proven difficult, and that is inadequate. The President's request was inadequate. In the face of rising Medicare costs, it is going to be even more difficult. That is why I have introduced legislation to provide incentives for Medicare contractor and payments safeguards funding to keep pace with the growth in the volume of claims.

This should be a vital component of any plan to reinvent Government, and I hope to get the administration's attention and support for this legislation.

We will begin this hearing with a panel representing the General Accounting Office and the HHS Office of Inspector General, to be followed by testimony from the Health Care Financing Administration. In addition to discussing the latest developments in payment safeguards, these agencies will highlight recent studies which reveal extravagant expenditure of Medicare funds by hospitals and corporate offices for such items as alcoholic beverages, and entertainment costs.

GAO REVIEW OF MEDICARE EXPENSES, CASE STUDY—UNALLOWABLE, QUESTIONABLE, AND UNSUPPORTED COSTS

Item	Unallowable	Questionable	Unsupported
Alcoholic beverages	\$17,755	.....	.....
Entertainment	51,013	.....	.....
Marketing and promotional activities	52,601	.....	.....
Professional services	78,391	.....	.....
Expenses for non-HCA employees	27,826	.....	.....
Foreign travel	53,657	.....	.....
Sponsorships, donations, and related expenses	16,932	.....	.....
Other expenditures	17,337	.....	.....
Scholarships	233,547	.....	.....
Dues and subscriptions .....	.....	\$53,553	.....
Awards, plaques, and gifts .....	.....	97,631	.....
Employee functions .....	.....	26,387	.....
Subsidized food costs .....	.....	137,359	.....
Other costs for concern .....	.....	102,041	.....
Unsupported .....	.....	.....	\$100,716
Total	549,059	416,972	100,716
Grand total .....	.....	1,066,747	.....

The GAO study found that one large company inappropriately charged Medicare hundreds of thousands of dollars in just 1 year for such items as travel to Italy, Belgium, and Australia, food and beverages for spouses and children attending company meetings, and Tiffany pitchers for hospital executives.

GAO review, case study—examples of inappropriate medicare charges

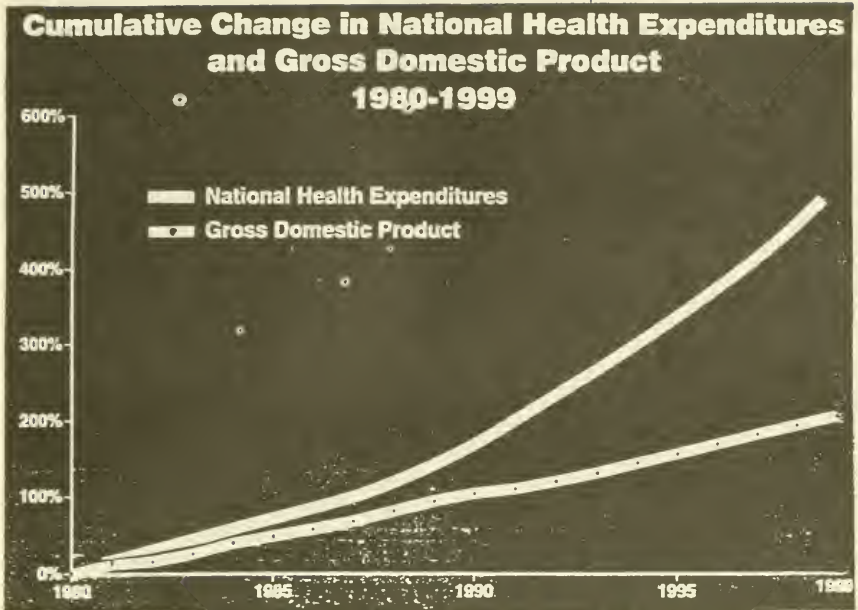
<i>Item</i>	<i>Cost</i>
Travel to Italy, Belgium, and Australia	\$53,657
Food and beverages for spouses and children attending company meetings	27,826
Researching company tax consequences	78,391
Scholarships for employees' children	233,547
Subsidizing employee tickets to the symphony, theatre, and ballet	14,523
Tiffany pitchers for hospital executives	14,912
Dinner cruises, including alcoholic beverages	3,053

The Inspector General's Office, in a review of 21 health care facilities, found inappropriate charges in excess of \$50 million for many of the same items identified by GAO. In one case, the inspector general found Medicare was charged for an insurance policy covering the cost of a Mercedes Benz automobile offered as a prize in a hospital's charity golf tournament. Scholarships for dependent children was also identified as a big fringe benefit, again charged to Medicare. That may be the most egregious of all.

Inexcusably, both GAO and the Inspector General's Office have found that these costs are not specifically disallowed in the Medicare Handbook which HCFA uses as a guide for its reimbursement policy. The guidelines merely say that allowable costs must be related to patient care. Clearly, more specific guidelines are needed, such as those contained in Federal acquisition regulations and OMB Circular A-21. I have been pressing HCFA to address this issue, and I look forward to their response today.

GAO REVIEW, CASE STUDY—COMPARISON OF ALLOWABILITY OF SELECTED EXPENSES

Expense	Medicare	Federal acquisition regulations	OMB Circular A-21
Alcoholic beverages	Not specifically mentioned.	Unallowable	Unallowable.
Entertainment	...do	...do	Do.
Contributions	...do	...do	Do.
Scholarships for dependents	...do	...do	Allowable.
Membership in civic organizations	Allowable	...do	Unallowable.
Subsidized food costs	...do	...do	Do.
Advertising	Unallowable	...do	Do.



STATEMENT OF SARAH F. JAGGAR

At this time, I would like to welcome Sarah Jaggar, Director of Health Care Financing and Policy Issues at the General Accounting Office, and June Gibbs Brown, the Inspector General of the Department of Health and Human Services.

I have your written statements and they will be made a part of the record in their entirety. I would ask you to summarize your prepared remarks. We will start with Ms. Jaggar.

Ms. JAGGAR. Thank you very much, Mr. Chairman, and good morning. We are pleased to be here today to discuss the importance of efforts to protect Medicare's benefit dollars from waste, abuse, and mismanagement. With me today is Tom Dowdal, assistant director, who has worked on Medicare issues and worked on the study you referred to looking at a large hospital corporation.

At \$146 billion a year, covering more than 35 million beneficiaries, and facing the need to process more than 700 million claims this year, the Medicare Program faces budgeting and management problems and challenges. Yet Medicare pays more claims with less scrutiny today than at any other time over the past 5 years, and is losing opportunities, we believe, to save hundreds of millions of dollars in Medicare payments.

We have found that budget constraints have resulted in underfunding key program safeguards that control the billions of dollars in benefit payments and create numerous problems for the Health Care Financing Administration, which is responsible for administering Medicare.

For example, one of HCFA's contractors had a 53-percent drop last year in the amount of money its payment safeguard program saved Medicare. HCFA has not asked why. Some contractors pay

many times more per Medicare beneficiary for certain procedures than others. HCFA does not ask why. One contractor had many more payment controls and saved Medicare more than twice that of another contractor, but HCFA's ratings of the two contractors were virtually the same.

Over the past year, HCFA has begun efforts to improve its use of Medicare data and has stepped up requirements for contractors to find and correct payment problems. Budget constraints, however, have compelled HCFA to cut contractor operating costs. HCFA contractors have a record, as you mentioned, of saving about \$14 for every \$1 spent on payment safeguards. Nevertheless, funding for Medicare claims review has decreased from 74 cents per claim in 1989 to 52 cents per claim in 1994. This is occurring at a time when Medicare is becoming ever more vulnerable to waste and abuse.

Recently, for example, doctors and other providers have been moving services out of such regulated environments as hospitals to largely unregulated freestanding facilities, contributing to an explosion in nonhospital claims, which are expected to total \$630 million in 1994. This is a 55-percent increase in these part B claims since 1989. When claims volume increases, but the number of safeguards staff remains constant or declines, the contractors' staff apply fewer or less stringent payment controls.

Payment controls help ensure that Medicare does not pay for unnecessary or inappropriate services. For example, when one contractor found that its spending for foot care services jumped more than threefold from about \$470,000 to about \$1.8 million between 1988 and 1991, it developed and implemented a payment control to deny uncovered or inappropriate foot care claims. By fiscal year 1992, the contractors' payments for foot care procedures dropped to about \$620,000, about one-third of its payment for these procedures in 1991.

Adequate funding really does make a difference in how much money contractors can save Medicare. In a demonstration project, HCFA provided special funding to three contractors. In comparing their payment safeguard accomplishments to that of two other contractors, the contractors with enhanced funding saved 170 percent more, and they accomplished this by taking some very basic actions. They employed about twice the number of program safeguard staff, they used about four times the number of computerized controls to flag questionable claims, and they reviewed nearly four times as many claim items.

In the past, we have recommended that the Congress modify budget procedures so that Medicare safeguard funding could be increased without having to cut spending elsewhere. Under the Budget Enforcement Act of 1990, the Congress increased appropriations for IRS compliance activities without necessitating spending cuts elsewhere. We think a similar method should be used for funding Medicare's payment safeguard activities.

The Medicare Program is also suffering from management weaknesses. HCFA has little information on such fundamental controls as the computerized edits that contractors use to flag questionable claims before making payments. Better information on such controls might help HCFA understand why in some locations Medicare

beneficiaries, for example, receive five times more chiropractic services than other locales.

Moreover, HCFA makes little use of its management reports to scrutinize contractor safeguard activities. This lack of attention to management reports may help explain why HCFA did not explore the circumstances surrounding the contractors' reported 53-percent drop in 1992 savings it achieved through claims review, a drop of about \$26 million. In fact, in 1992, HCFA gave that contractor its maximum score for the relevant segments of its program's safeguard activities in its rating system.

In addition to reducing contractor claims review funding, HCFA has also significantly reduced contractors' funds for auditing hospitals and other facilities.

Our recent review of the general and administrative expenses of a large hospital chain, the Hospital Corporation of America, illustrates why it is necessary to periodically review the submitted cost of hospitals and other institutions. Of the \$2.6 million of HCA's general and administrative expenses that we examined, we identified \$1.1 million that we considered to be unallowable, questionable, or unsupported. As illustrated on the chart that you have placed here, this amount includes money for alcoholic beverages, entertainment, and employee meetings and other functions, and substantial funds for scholarships and related expenses for children of HCA employees.

In our opinion, the general nature of the Medicare cost principles was a major reason why HCA included unallowable and questionable costs in its Medicare cost reports. Providers and contractors need clearer guidance from HCFA to interpret and enforce Medicare rules.

HCFA is aware of these problems and is undertaking some steps to address them. In the past year, they have implemented a new data analysis approach called focused medical review that requires contractors to begin systematically addressing payment problems. Its success is not yet proven, but funding reductions have seriously limited the potential of focused medical review, this new undertaking, to achieve control of Medicare expenditures.

HCFA is also planning to consolidate its multiple automated systems for claims processing into a single, automated system as part of an overall strategy to improve the efficiency and effectiveness of Medicare operations. HCFA believes the consolidation may enhance contractor management and HCFA's ability to compare data on contractors' workload, savings resulting from payment controls, and other performance indicators.

In our view, opportunities to curb unnecessary Medicare expenditures are being lost. Strong evidence suggests that an adequately funded and managed safeguard program could help the Medicare Program avoid many millions of dollars of unnecessary expenditures. Consequently, we believe the Congress should continue to pursue efforts to modify budget procedures so that Medicare safeguard funding could be increased without having to cut spending elsewhere.

PREPARED STATEMENT

In addition, we believe that HCFA needs to develop an effective strategy to manage contractors' payment safeguard activities. This would entail making identification and correction of payment problems a high agency priority. Such a strategy could help ensure that Medicare has the controls in place to aggressively fight waste and abuse.

Mr. Chairman, this concludes my testimony. I will be glad to answer any questions that you may have.

Senator HARKIN. Thank you very much.

[The statement follows:]

STATEMENT OF SARAH F. JAGGAR

SUMMARY

Medicare's role as the largest payer in the health care industry, which consumes nearly one-seventh of our gross domestic product, underscores the importance of administering the program effectively. In fiscal year 1993 Medicare cost \$146 billion, covered about 35 million beneficiaries, and processed about 700 million claims. If current trends continue, Medicare expenditures are expected to increase to \$259 billion by 1998. Due to budgeting and management problems, the government pays too little attention to the activities protecting Medicare benefit dollars and is losing opportunities to save many millions of dollars in Medicare payments.

The Health Care Financing Administration (HCFA) administers the Medicare program. It contracts with insurance companies like Blue Cross and Blue Shield, Travelers, and Aetna to process claims and perform payment control activities, called payment safeguards. In performing this work the companies, or contractors, use various controls to avoid making unnecessary or inappropriate payments.

Despite the rising volume of Medicare claims, contractors' per claim funding for payment safeguards has declined since 1989 by over 20 percent. Much of this money pays for staff who develop payment controls and review claims. In response to reduced per claim funding, contractors apply fewer or less stringent payment controls to keep the review workload manageable.

The results of an HCFA demonstration project show a positive relationship between investing in payment safeguards and preventing program losses resulting from mistaken payments. In this project, three contractors receiving special funding from HCFA saved 170 percent more, after expenses, than the project's control contractors.

In efforts to protect benefit dollars, HCFA faces management challenges that compound the funding reduction problems. HCFA has little information on such fundamental controls as the computerized edits and payment criteria that contractors use in reviewing claims before making payment. Moreover, HCFA makes little use of data management reports to scrutinize contractor safeguard activities.

GAO believes that with an adequately funded and managed safeguard program, Medicare could avoid many millions of dollars of unnecessary expenditures. Thus, GAO believes the Congress should continue to pursue efforts to modify budget procedures so that Medicare's safeguard funding could be increased without having to cut spending for other government programs. In addition, HCFA needs to better manage contractors' payment safeguard activities. It should establish the infrastructure needed to make identification and correction of payment problems a high agency priority. Such actions could help assure that Medicare has the controls in place to aggressively fight waste and abuse.

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the importance of efforts to protect Medicare's benefit dollars from waste, abuse, and mismanagement. At other hearings and in reports recently issued,¹ we have made recommendations about Medicare administrative funding and the need to better manage specific functions. Today we would like to reiterate our funding recommendation and discuss management problems from a broader, systemic perspective. In particular, we would like to point out that because of budgeting and management problems, Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. The government pays too little attention to

¹ See appendix for a list of reports and testimonies.

the activities protecting Medicare benefit dollars and is losing opportunities to save hundreds of millions of dollars in Medicare payments.

Medicare's role as the largest payer in an industry that consumes nearly one-seventh of our gross domestic product makes it imperative, in our view, that the program be effectively administered. Under recent health reform proposals, Medicare would continue to have a major economic and policy impact on the health care industry.

In fiscal year 1993 Medicare cost \$146 billion, covered about 35 million beneficiaries, and processed about 700 million claims.

If current trends continue, Medicare expenditures are expected to increase to \$259 billion by 1998. Soaring expenditures for health care underscore the need for the government to fund and manage Medicare judiciously, but budget constraints have resulted in underfunding key program safeguards that control the billions of dollars in benefit payments. What compounds this problem is that the Health Care Financing Administration (HCFA), which is responsible for administering Medicare, faces many challenges in managing its national network of some 80 claims processing and payment contractors to which it delegates program safeguard activities.

We found, for example, through data reported to and sometimes generated by HCFA, that:

- HCFA did not determine why one of its contractors had a 53-percent drop last year in the amount of money its payment safeguard program saved Medicare.
- Some contractors have paid many times more per Medicare beneficiary for certain procedures than others, suggesting that some contractors have stiffer payment controls than others. HCFA does little to compile or evaluate information on contractors' payment controls to help explain why certain spending varies so significantly across contractors.
- One contractor had many more payment controls and saved Medicare more than twice that of another contractor. HCFA's rating of the two contractors did not reflect the greater accomplishments of the more successful contractor.² This lack of emphasis on payment controls is a factor that discourages contractors from making improvements.

Over the past year HCFA has begun efforts to improve its use of Medicare data and has stepped up requirements for contractors to find and correct payment problems. Budget constraints in recent years, however, have compelled HCFA to cut contractor operating costs, which amount to slightly over 1 percent of Medicare's total expenditures. HCFA contractors have a record of saving about \$14 for every dollar spent on payment safeguards; nevertheless, funding for Medicare claims review has decreased from 74 cents per claim in 1989 to an expected 52 cents per claim in 1994. These cuts have had a significant effect on how effectively contractors control the billions of dollars of benefit payments. Simply put, fewer dollars spent on contractor operations mean more claims paid without adequate review and increased spending for unnecessary or inappropriate services.

HCFA ADMINISTERS MEDICARE LARGELY THROUGH PRIVATE INSURERS

In 1965, when the Medicare program was enacted, the law called for insurance companies—like Blue Cross and Blue Shield, Travelers, and Aetna—to process and pay claims. Under the law, the insurers, called Medicare contractors, use federal funds to pay health care providers and beneficiaries and are reimbursed for their administrative expenses incurred in performing the work.

Over the years, HCFA has consolidated some of Medicare's operations and the number of contractors has fallen from about 130 to about 80 today. Their duties encompass three major functions: claims processing, provider and beneficiary services, and payment control activities, called payment safeguards. In 1993 the contractor budget is approximately \$1.6 billion, with about 26 percent devoted to payment safeguard activities.

CONTROLS OVER MEDICARE PAYMENTS DETERIORATE DUE TO BUDGET CONSTRAINTS

The importance of contractors' vigilance over payments is growing because of the increasingly complex environment in which contractors operate. In recent years doctors and other providers have been moving more services out of such regulated environments as hospitals to largely unregulated and sometimes unlicensed freestanding facilities. This has contributed in part to an explosion of nonhospital claims that

² HCFA has a contractor performance evaluation program to rate contractors on various dimensions, such as the accuracy of claims processing and compliance with program safeguard requirements.

Medicare has to pay. Compared to 116 million claims for inpatient and outpatient hospital services, nonhospital claims are expected to total 630 million claims in 1994. This represents a 55-percent increase in such claims since 1989.

Despite the rising volume of claims, contractors' per-claim funding for payment safeguards has declined since 1989 by over 20 percent. The largest portion of contractor safeguard funding pays for staff who develop payment controls, review claims, and investigate suspect providers. When claims volume increases but the number of safeguard staff remains constant or declines, contractor staff apply fewer or less stringent payment controls.

Payment controls help ensure that Medicare does not pay for unnecessary or inappropriate services. For example, when one contractor found that its spending for foot care services jumped more than threefold—from about \$470,000 to about \$1.8 million between 1988 and 1991—it developed and implemented a payment control to deny uncovered or inappropriate foot care claims. By fiscal year 1992, the contractor's payments for foot care procedures dropped to about \$620,000—about a third of its payments for these procedures in 1991.

At contractors we recently visited, funding constraints have led to less effort spent developing payment controls, some of which are computerized and can flag questionable claims during automated processing. Staff are not available to develop these controls or to investigate the claims that have been suspended for review when such controls are applied. One contractor told us that the suspended claims workload created by existing controls overwhelmed the review staff and, therefore, adding new controls was not a priority. Several contractors even eliminated certain controls because the volume of suspended claims exceeded the capacity of the staff to process them promptly.

Moreover, annual per-claim funding reductions have led HCFA to lower the proportion of claims that contractors must review. In 1989 HCFA set targets for contractors to suspend and review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994. HCFA also reduced by a third the number of audits of providers that contractors are required to perform. In the face of these significant reductions in claims reviewed, HCFA has encouraged contractors to focus their reviews systematically on the more egregious payment problems.

POTENTIAL SAVINGS ARGUES FOR FUNDING INCREASES FOR CLAIMS REVIEW

The results of a HCFA demonstration project, which we are currently reviewing, help explain how adequate funding of payment safeguards can reduce program losses. In this project, HCFA provided special funding to three contractors and compared the contractors' payment safeguard accomplishments to that of two other contractors that did not receive enhanced funding. The contractors with enhanced funding saved 170 percent more, after expenses, than the other contractors. The enhanced funding permitted them, in comparison to the lower-funded contractors, to

- Employ over twice the number of program safeguard staff,
- Use four times the number of computerized controls to flag questionable claims, and
- Review before making payment nearly four times as many claim items.

In the current budget environment, funding increases appear unlikely, despite the proven record of claims reviews at saving Medicare substantially more than it costs. HCFA's fiscal year 1994 budget for contractor safeguard activities provides for an absolute 6 percent funding decrease; on a per claim basis, this means that contractors are expected to have about 12 percent less than last year for their claims review activities. Continuing declines can be expected as long as payment safeguard activities funded out of Medicare's administrative appropriations are considered part of federal discretionary spending and must compete against program funds for scarce dollars.

In the past we have reported that the Congress should consider modifying budget procedures so that Medicare safeguard funding could be increased without having to cut spending elsewhere.³ Presently, administrative funding can be increased only if funding for other programs, such as immunizations or job training, is reduced. For example, although an additional \$10 spent on program safeguard activities could save \$140 in Medicare spending, no credit would be given (or scored) for the savings,

³ Our proposal to amend the Budget Enforcement Act is included in a May 1991 report entitled Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

while the \$10 would be counted as an increase in federal discretionary spending levels.

Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service (IRS) compliance activities without necessitating spending cuts elsewhere. As we reported in 1991, we believe using IRS' method of funding compliance activities as a model would enable the Congress to appropriate the funding needed for Medicare contractors' staffing and performance of payment safeguard activities. The Congress enacted our recommendation in 1992 but the bill was vetoed by the President for other reasons.

HCFA MANAGEMENT CHALLENGES COMPOUND FUNDING PROBLEMS

The Medicare program is also suffering from management weaknesses. HCFA has little information on such fundamental controls as the computerized edits and payment criteria that contractors use in reviewing claims before making payment. Moreover, HCFA makes little use of its management reports to scrutinize contractor safeguard activities. This lack of attention to management reports may help explain why HCFA did not explore the circumstances surrounding a contractor's reported 53-percent drop (amounting to over \$26 million) in the 1992 savings it achieved through claims review. In fact, in 1992 HCFA gave the contractor a maximum score for the relevant segment of its program safeguard activities.

Similarly, HCFA does not make effective use of data compiled on contractors' spending for procedures to help explain large disparities in spending between contractors. For example, 1,000 Medicare enrollees in Arizona receive, on average, about 700 chiropractic manipulations per year, while in Louisiana the same number of Medicare enrollees receive only about 150 manipulations. Despite this disparity, HCFA has not assessed whether the differences between contractors serving Arizona and Louisiana are related to payment controls or some other factor that HCFA or the contractors should address. Yet for chiropractic manipulation, Medicare spent over \$185 million in 1992.

In the course of several reviews, contractors we visited pointed to instances where Medicare payments were growing rapidly and they had not yet addressed whether payment controls were needed. For example, one contractor:

- Experienced an annual growth rate in basic ambulance services of about 30 percent over the past 5 years. The contractor believes much of the increase could result from the use of ambulances for routine transportation, a noncovered service. Ambulance services were the fourth largest category of the contractor's expenditures, yet no computerized controls existed to flag questionable claims. Nationwide, Medicare spent over \$1 billion for ambulance services in 1992. Basic emergency ambulance services alone represent the eighth largest amount Medicare spends for a nonhospital service.
- Saw over a 15-fold increase, from about \$580,000 to \$10 million between 1989 and 1991, for echocardiograms (a procedure that allows doctors to view an image of the heart). In 1992 Medicare's spending nationwide for one kind of echocardiogram—\$366 million—ranked ninth largest in amounts spent on a nonhospital service.

HCFA REDUCES AUDITS OF HOSPITALS AND OTHER FACILITIES

Providers such as hospitals, home health agencies, and nursing homes are reimbursed, at least in part, on the basis of their costs of providing services. Between 1989 and 1993, funding for HCFA's auditing of these facilities has decreased from 27 cents to 22 cents per claim and in 1994 is expected to drop to 19 cents per claim.

Our recent review of the general and administrative expenses of a large hospital chain—Hospital Corporation of America (HCA)—illustrates why it is necessary to periodically review the submitted costs of hospitals and other institutions.⁴ Of the \$2.6 million of HCA's general and administrative expenses that we examined, we identified \$1.1 million that we consider to be either unallowable, questionable, or unsupported. This amount includes:

- \$17,755 for alcoholic beverages at various employee meetings and functions,
- \$51,013 for entertainment at employee meetings and other functions, and
- \$233,547 for scholarships and related expenses for children of HCA employees.

⁴ Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD-94-13, Oct. 15, 1993).

HCFA BEGINS EFFORTS TO IMPROVE MANAGEMENT OF PROGRAM SAFEGUARDS

Over the past year, HCFA implemented a new data analysis approach, referred to as focused medical review, that requires contractors to begin systematically addressing payment problems. Specifically, HCFA now requires the contractors to identify services or procedures that have inappropriately high utilization and take action to reduce that utilization. Though HCFA's new approach can significantly improve Medicare contractor payment controls, funding reductions have seriously limited the potential of focused medical review to achieve control of Medicare expenditures. Program safeguard activities require staff to review records and assess medical necessity. Thus, staffing will continue to be a major constraint as long as safeguard funding continues to lag behind the growth in Medicare claims.

HCFA is also planning to consolidate its multiple automated systems for claims processing into a single automated system as part of an overall strategy to improve the efficiency and effectiveness of Medicare operations. HCFA believes the proposed consolidation has the potential to enhance contractor management. A single system would format claims data uniformly and would enhance HCFA's ability to compare data on contractors' workload, savings resulting from payment controls, and other performance indicators. In addition, HCFA believes that a single claims processing system would allow it to designate contractors specifically to focus on activities exclusive of claims processing, such as program safeguards. HCFA expects to award a contract to begin developing the system in early 1994 and have the system developed and tested by late 1996.

CONCLUSIONS

Currently, the administrative budgets of federal programs are facing cuts. In our view, given the condition of the Medicare safeguard program, reductions in Medicare's administrative budgets should not be made without careful consideration of the likely effect on benefit payments. Over the past 5 years, Medicare's program safeguards budget, on a per claim basis, has declined appreciably. As a result, opportunities to curb unnecessary Medicare expenditures are being lost. Strong evidence suggests that with an adequately funded and managed safeguard program, Medicare could avoid many millions of dollars of unnecessary expenditures. Consequently, we believe the Congress should continue to pursue efforts to modify budget procedures so that Medicare's safeguard funding could be increased without having to cut spending elsewhere.

In addition, we believe that HCFA needs to develop an effective strategy to manage contractors' payment safeguard activities. This would entail establishing the infrastructure needed to make identification and correction of payment problems a high agency priority. Such a strategy could help ensure that Medicare has the controls in place to aggressively fight waste and abuse.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions.

APPENDIX

Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD-94-13, Oct. 15, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (GAO/T-HRD-93-4, Feb. 17, 1993).

High-Risk Series: Medicare Claims (GAO/HR-93-6, December 1992).

Medicare: One Scheme Illustrates Vulnerabilities To Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (GAO/HRD-92-64, June 12, 1992).

Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992). Testimony on same topic (GAO/T-HRD-92-29, May 7, 1992).

Medicare: Over \$1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991).

STATEMENT OF JUNE GIBBS BROWN

Senator HARKIN. I will have Ms. Brown testify and then we will get to questions.

Ms. Brown, welcome to the subcommittee. Your statement will be made a part of the record. Please proceed as you so desire.

Ms. BROWN. Thank you, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services, and with me today is George M. Reeb, Assistant Inspector General for Health Care Financing Audits.

This is my first appearance before the subcommittee since my confirmation last week, and I would like to thank both you and your staff for the support extended during that confirmation process. I am going to submit my full testimony for the record.

The Office of Inspector General, which was created in 1976, is charged with protecting the integrity of departmental programs as well as promoting their economy, efficiency, and effectiveness. I am proud to lead one of the most respected organizations in the Federal Government. Our audit investigations and inspection activities are well known to this subcommittee.

At your request, my remarks are going to focus on two issues, our oversight work on payment safeguard activities and at the Health Care Financing Administration and our recent audits of hospital general and administrative costs.

The HCFA administers health care programs which provide health service coverage to approximately 36 million beneficiaries age 65 and older and to certain disabled individuals. They contract with over 80 contractors, called fiscal intermediaries and carriers, who pay over 700 million claims annually to approximately 600,000 providers.

Medicare beneficiaries and contractors serve the Medicare Program's front line defense against fraud and abuse. The contractors implement a number of payment safeguard initiatives which are designed to control costs and overutilization and detect fraud. These payment safeguard activities play an important role in detecting fraud, waste, and abuse in Medicare, and as both of you have pointed out in your statements, they save from \$14 to \$16 for each \$1 spent.

Where adequately funded, we have found that overall payment safeguards do work and contribute to the reduction of fraud and abuse in Medicare. However, inadequate funding affects program controls to detect false or improper Medicare payments, and the losses to the Medicare Program can run into the billions. With health care reform on the horizon, we need to ensure that our programs and policies are sound and efficient and that payment safeguard activities are as effective as possible.

Medicare payment safeguard activities were funded at \$400 million in fiscal year 1993, and are expected to save the Medicare Program about \$6 billion. The budget for fiscal year 1994 includes \$390 million for these activities, with anticipated savings of about \$5.6 billion.

HCFA has identified and continues to report the lack of adequate funding for payment safeguards as a material weakness in its Federal Managers Financial Integrity Act report to the President and to the Congress. We issued a report in August 1992 on the corrective actions taken by HCFA to improve the funding of contractors' payment safeguard activities during fiscal years 1990-91.

Our review showed that although total funding was relatively stable, the allocation of the funds to the four areas of payment safeguards was not. Funding had decreased in the MSP and medical review, utilization review areas, and this created problems in maintaining adequate, well-trained and experienced staff in processing the MSP cases.

We found that contractors were able to initiate all needed recovery actions on potential MSP cases. As a result, backlogs developed to as much as \$1.1 billion. The HCFA has moved to improve in this area, and has consistently requested additional funds for payment safeguard activities.

In spite of funding shortfalls, HCFA initiated changes to be more efficient with less resources. These initiatives include the moving away from case-by-case review of suspected incorrect payments and instead focusing on patterns and trend analysis of payment data and provider profiling.

The approach, known as focused medical reviews, permits identification of providers with aberrant billing and utilization patterns. Although we applaud their efforts, overutilization, overpayments, and fraud cases continue to consume significant resources. Our audit investigations and inspection activities are continually evaluating the adequacy of payment controls at Medicare contractors. Our reviews of Medicare payments continue to identify overpayments, overutilization of services, and fraud.

The four major payment safeguard activities supported by HCFA and performed by Medicare contractors include the medical utilization review, benefits integrity, provider audit, and the Medicare secondary payer, which I refer to as MSP before.

A brief description of each of those payment safeguard activities and some of our work in the area is included in my written statement for the record.

On the second subject, I would now like to discuss the results of our review of general and administrative costs and fringe benefit costs at 19 hospitals and two home offices of hospital corporations. We recently provided the subcommittee staff with the results of our review, which identify unallowable general and administrative cost and fringe benefit costs of about \$47.4 million. I will briefly summarize the results.

Our review analyzed selected general administrative cost and fringe benefit costs to determine first if such costs were allowable, reasonable, and allocable under Medicare cost principles as set forth in the "Medicare Providers Reimbursement Manual" published by HCFA; second, the nature of the charges and the degree of relationship to patient care activities; and third, those types of costs which may be perceived to be extravagant or otherwise inappropriate.

The 21 providers in our review claimed total general and administrative cost, and fringe benefit cost, of \$716.8 million, of which we reviewed \$228.4 million.

It is important to note, Mr. Chairman, that in selecting the cost for review, we included those items which we believed had the greatest risk of noncompliance with Federal regulations, and of being unrelated to patient care. So, therefore, the results of our analysis cannot be considered representative of the entire 21 providers included in our review.

However, almost 75 percent of unallowable general and administrative cost dealt with self insurance and undocumented expenditures. The remaining 25 percent of unallowable cost fell into several categories, including personal perks, marketing, social activities, donations, legal consultants, and other miscellaneous groupings.

We found numerous instances of costs charged to Medicare for parties, liquor, golf, club outings, and membership fees in social clubs; that hospitals believe are allowable, but have no relationship to patient care and, therefore, we believe are unallowable.

Some unallowable costs identified were explicitly unallowable, and have resulted primarily from the provider's lack of internal controls over costs included in the Medicare cost reports. We are also recommending, however, that HCFA clarify its guidance to the providers, regarding the allowability of costs.

Our audits focused on general and administrative and fringe benefit costs included in hospitals' Medicare cost reports. The effect that any unallowable cost would have on Medicare expenditures depends on which of the two methods—prospective payment and reasonable cost—a hospital is reimbursed.

Our results demonstrate a need for more explicit guidelines on the allowability of certain general and administrative costs, and fringe benefit costs charged to the Medicare Program. There is too much reliance on the broadly defined cost concepts of reasonableness, relationship to patient care, and the prudent buyer concept, without explicit instructions on how these concepts should be applied to specific costs. Even some of the providers mentioned the need for clearer guidelines.

PREPARED STATEMENT

In our draft summary report, we recommend that HCFA revise the provider reimbursement manual to provide additional clarification on the allowability of specific types of general and administrative and fringe benefit costs.

I would be happy to answer any questions that the committee may have.

[The statement follows:]

STATEMENT OF JUNE GIBBS BROWN

Good morning Mr. Chairman and members of the subcommittee. I am June Gibbs Brown, Inspector General for the Department of Health and Human Services. With me today is George M. Reeb, Assistant Inspector General for Health Care Financing Audits. This is my first appearance before a subcommittee since my confirmation and I would like to thank the chairman and his staff for their support and assistance extended during the confirmation process. I sincerely appreciate everyone's efforts.

The Office of Inspector General, created in 1976, is charged with protecting the integrity of departmental programs as well as promoting their economy, efficiency, and effectiveness. I am proud to lead one of the most respected organizations in the Federal Government. Our audit, investigations and inspections activities are well known to this subcommittee. Last year, the Office of Inspector General (OIG) generated savings, fines, restitutions, penalties, and receivables of over \$61 for each Federal dollar invested in its operation and we will strive to continue these results during the coming years. Again, we greatly appreciate your support as Chairman of this subcommittee and your efforts to ensure that we have adequate resources.

The subcommittee requested that my remarks focus on two issues: our oversight work on payment safeguard activities at the Health Care Financing Administration (HCFA) and our recent audits of hospital general and administrative costs. More specifically, your letter asked that we review the current status of payment safeguard activities; discuss any potential for current improvement, and with regard to general and administrative expenses, highlight the types and amounts of expenditures which we considered unallowable and questionable. I would like to preface my remarks by mentioning that we are working very closely with HCFA to resolve many of the problems cited by our reports. The HCFA has implemented many of our recommendations and improved upon many others and I look forward to developing this partnership in the coming years.

MEDICARE PAYMENT SAFEGUARDS

The HCFA administers the Medicare program which provides health insurance coverage to approximately 36 million beneficiaries aged 65 or older and to certain disabled individuals. The HCFA contracts with over 80 contractors (called fiscal intermediaries and carriers) who pay over 700 million claims annually to approximately 600,000 providers. Medicare beneficiaries and contractors serve as the Medicare program's frontline defense against fraud and abuse.

The contractors implement a number of payment safeguard initiatives which are designed to control costs and over-utilization, and detect fraud. These payment safeguard activities play an important role in detecting fraud, waste, and abuse in Medicare. These activities are reported to save from \$14 to \$16 for each dollar spent. Where adequately funded, we have found that, overall, payment safeguards do work and contribute to the reduction of fraud and abuse in Medicare. However, inadequate funding affects program controls to detect false or improper Medicare payments, and the losses to the Medicare program can run in the billions. With health care reform on the horizon, we need to ensure that our programs and policies are sound and efficient and that payment safeguard activities are as effective as possible.

The 4 major payment safeguard activities supported by HCFA and performed by Medicare contractors include:

- Medical/utilization review;
- Benefits integrity;
- Provider audit; and
- Medicare secondary payer (MSP).

Before addressing each of these areas in detail, I would like to discuss funding issues involving payment safeguards.

Medicare payment safeguards activities were funded at \$400 million in fiscal year 1993 and are expected to save the Medicare program about \$6 billion. The budget for fiscal year 1994 includes about \$390 million for these activities with anticipated savings of about \$5.6 billion.

The HCFA has identified and continues to report the lack of adequate funding of payment safeguards as a material weakness in its Federal Managers Financial Integrity Act report to the President and Congress. We issued a report in August 1992 on the corrective actions taken by HCFA to improve on the funding of contractors' payment safeguard activities during the 1990 to 1991 fiscal years. Our review showed that although total funding was relatively stable, the allocation of the funds to the four areas of payment safeguards was not. Funding had decreased in the MSP and medical review/utilization review areas. This created problems in maintaining adequate, well-trained and experienced staff and in processing MSP cases. We found that contractors were not able to initiate all needed recovery actions on potential MSP cases. As a result, backlogs developed to as much as \$1.1 billion. The HCFA has moved to improve in this area and has consistently requested additional funds for payment safeguards activities.

In spite of funding shortfalls, HCFA initiated changes to be more efficient with less resources. These initiatives include moving away from case by case review of suspected incorrect payments and instead focus on pattern and trend analysis of

payment data and provider profiling. This approach, known as focused medical reviews, permits identification of providers with aberrant billing and utilization patterns. Although we applaud their efforts, overutilization, overpayments and fraud cases continue to consume significant resources.

Our audit, investigations and inspections activities are continually evaluating the adequacy of payment controls at Medicare contractors. Our reviews of Medicare payments continues to identify overpayments, overutilization of services and fraud. The following is a brief description of each payment safeguard activity and some of our work in each area.

MEDICAL/UTILIZATION REVIEW

Medical utilization review activities identify unnecessary or inappropriate services delivered in other than an inpatient acute care setting. They are designed to ensure that the services rendered are necessary and that Medicare pays a reasonable amount. Last year, Medicare contractors denied almost 28 million of the over 600 million claims filed (4.7 percent) for services that were medically unnecessary or not covered by Medicare. These claims are detected using computer edit reviews established by HCFA. Expenditures for medical utilization and review are expected to total \$120.6 million in fiscal year 1994 and result in savings of \$901 million.

These edit routines, however, do not prevent all the fraud, abuse, and wasteful practices in the health care delivery system. The following examples are provided to illustrate some of our work in this area.

An OIG review of clinical laboratory services showed that the Medicare program pays twice the amount for laboratory tests than other payers. These reviews led to the identification of schemes in which laboratories would manipulate physicians into ordering additional medically unnecessary tests whenever they ordered a basic automated chemistry panel. We found instances where laboratories would charge physicians \$.65 for a test and bill Medicare for the same test between \$12 and \$19. The Department of Justice is very active in prosecuting these cases. In one of the largest settlements in recent history, National Health Laboratories, Inc. paid back \$100 million to Medicare and \$10.4 million to State Medicaid programs based on the joint investigative and audit work of our office and the Department of Justice. In addition, the corporation paid a \$1 million criminal fine and the corporation's president paid a \$500,000 criminal fine.

To identify causes for increases in health care expenditures, we reviewed physicians' claims for Medicaid and Medicare Part B services. Although our review to date is limited to one large Medicare contractor and one Medicaid State Agency, we find that physicians have the ability to manipulate the codes for billing services thereby increasing their payments from Medicare and Medicaid. In our tests for procedure unbundling in surgical codes in the Medicare claims, we found that 3 percent of all single surgery and 28 percent of all multiple surgery claims contained a coding manipulation or overpayment problem. For an example of this situation, consider a hysterectomy billing. A physician could bill three Medicare codes totaling \$4,800 or one comprehensive code totaling \$2,800. Splitting the procedure into different codes, results in a 42 percent difference in payment.

The potential for annual overpayments at one carrier could amount to nearly \$13 million in Medicare Part B and over \$1 million in Medicaid at one State. Multiply this by the number of claims processed by all Medicare carriers and Medicaid State agencies, and one can recognize the significant impact this has on the rising costs of Federal health care. The HCFA, although initially not in agreement with us on this issue, is considering the development of expanding national computer edits that could be used by all the carriers to reduce the unbundling of procedure codes.

In a separate review, we found that, contrary to Federal regulations, hospitals under the prospective payment system (PPS) were reimbursed for nonphysician outpatient services, such as laboratory services, rendered on the day before, the day of, or during an inpatient stay. Costs of such services are included in the PPS rate. The OIG estimates that improper Medicare payments of approximately \$107 million were made by Medicare fiscal intermediaries to PPS hospitals from the inception of PPS through October 1990. In addition, the OIG identified at least \$12.9 million due beneficiaries representing the coinsurance and deductible portions of the improper charges.

In addition to recommending that HCFA recoup overpayments, we also recommended that HCFA strengthen procedures to detect and avoid future overpayments. So far, HCFA reports that it has collected \$95 million from providers and that it has strengthened procedures.

BENEFITS INTEGRITY

In 1993, HCFA established separate Medicare fraud units in about 40 contractor sites. These units are responsible for proactively detecting fraud and abuse and referring cases to our office for further criminal investigation. The budget has earmarked \$24.8 million for benefit integrity in fiscal year 1994.

Our involvement with HCFA has resulted in a number of activities to promote the detection of fraud and abuse, including:

- Co-sponsoring national fraud and abuse conferences to kickoff HCFA's anti-fraud and abuse campaign.
- Participating with HCFA on a fraud and abuse technical advisory group with representatives from 15 carriers, 5 intermediaries, and 1 beneficiary group. The purpose of the group is to surface issues relating to fraud detection and advise HCFA on proposed fraud related policies and procedures.
- Working with HCFA on conducting a basic Medicare fraud investigation course for carrier fraud unit employees. The goal of the course was to instill the skills fraud unit staff need to effectively detect and document fraud and abuse.

MEDICARE AS SECONDARY PAYER

For the first 15 years of the Medicare program, Medicare was the primary or first payer for all health claims except when the claimant was covered by workers' compensation, black lung or veterans benefits. Beginning in 1980, Congress passed a series of laws which established Medicare as the secondary payer to other insurers in certain situations. Medicare is generally the secondary payer under the following situations:

- When the beneficiary has coverage under an automobile, no-fault of liability insurance plan;
- When the beneficiary has kidney failure (end stage renal disease) during their first 18 months of Medicare entitlement and they have coverage under an employer group health plan (EGHP) provided by an employer of 20 or more persons;
- In cases where the person is aged 65 or older and has EGHP coverage (or their spouse has coverage); and
- Beneficiaries who are disabled and covered under an EGHP provided by an employer of 100 or more persons.

The 1994 budget includes \$101.2 million for MSP activities and about \$3.6 billion in savings are expected.

Numerous reports issued in recent years by my office, the General Accounting Office, and HCFA continue to identify MSP problems. Possibly \$1 billion is being lost annually because Medicare pays claims which should be paid by private insurers. We began our work in the MSP area in the early 1980s when we first reported that anticipated savings from the initial law on EGHP were not being realized. We have found that in order to solve the MSP problem, Medicare needs to know of private insurance before making payments. The HCFA agreed that this lack of basic health coverage information and the resultant incorrect Medicare payments was a material internal control weakness and included it in the Secretary's 1989 Federal Managers' Financial Integrity Act report to the President and the Congress. The Department continues to report the MSP issue as a high risk area and as a material weakness.

At HCFA's request, we are currently performing audits at selected insurance companies and fiscal intermediaries to determine if they are complying with MSP provisions. For example, in its legal actions against Provident Life and Casualty Insurance Company, the Department of Justice, with assistance from our audit staff, recently settled with Provident whereby \$27 million will be returned to Medicare and Provident will assist in identifying additional overpayments made to providers.

In addition, recently enacted legislation requires a data match between the HCFA, Social Security Administration, and the Internal Revenue Service. The data match assists HCFA in identifying MSP cases, especially those resulting from spouses with health coverage through employment. We provided technical assistance to HCFA which expedited actions to implement the data match legislation. The HCFA has made great progress in identifying Medicare payments made on behalf of Medicare beneficiaries who had some form of insurance. To date, HCFA records indicate that about \$40 million has been collected as a result of this data match initiative. We are reviewing HCFA's actions to assure the overpayments are adequately identified and collected.

The HCFA is also charged with operating a "clearing house" of insurance information which was authorized by the recently enacted Omnibus Budget Reconciliation Act of 1993. We have recently met with HCFA staff and have offered our help in implementing this potential cost effective technique in identifying other payers. We

still have concerns, however, because of the historical nature of the insurance coverage data. There remains the need to have a current, accurate data base of health insurance coverage that could be accessed before making the Medicare payment.

PROVIDER AUDITS

A fourth major payment safeguard activity is that of auditing cost reports for hospitals and other Medicare Part A providers that are paid partly or completely on the basis of cost incurred. In performing audits, fiscal intermediaries examine the reasonableness of costs incurred by providers and disallow costs that are unreasonable or not related to Medicare. In 1993, provider audits by contractors resulted in program savings of about \$1.7 billion. The fiscal year 1994 budget request included a planned expenditure of \$141.9 million for provider audits, with an expected savings of about \$1.1 billion.

We conducted external quality control reviews of the audit operations of 14 Medicare intermediaries to determine if the fiscal intermediaries had: (1) established and were following adequate audit policies and procedures and (2) adopted and were following applicable auditing standards. We also reviewed the guidance issued by HCFA to the intermediary auditors.

We found that many of the 14 intermediaries did not fully meet a majority of the 9 government auditing standards. We believe that intermediary audits should be better planned, executed, and documented to be in accordance with government auditing standards. We recommended that they strengthen their audit policies and procedures and comply with government auditing standards to which the intermediaries generally agreed.

During our review, the HCFA started corrective action on these problems through revisions to its policies governing the provider audit function. We believe these revisions complement the corrective actions taken by the intermediaries and will enhance the quality of audits. We will be working with HCFA to ensure that intermediaries comply with all government auditing standards.

GENERAL AND ADMINISTRATIVE COST REVIEW

At the request of the subcommittee, I would now like to discuss the results of our review of general and administrative costs and fringe benefit costs at 19 hospitals and 2 home offices of hospital corporations. We recently provided the subcommittee staff with the results of our review which identify unallowable general and administrative costs and fringe benefit costs of about \$47.4 million. I will briefly summarize the results of our review.

Our review analyzed selected general and administrative costs and fringe benefit costs to determine: (1) if such costs were allowable, reasonable and allocable under Medicare cost principles as set forth in the Medicare providers reimbursement manual published by the HCFA; (2) the nature of the charges and the degree of relationship to patient care activities; and (3) those types of costs which may be perceived to be extravagant or otherwise inappropriate.

The 21 providers in our review claimed total general and administrative costs and fringe benefit costs of \$716.8 million of which we reviewed \$228.4 million. It is important to note, Mr. Chairman, that in selecting costs for review, we included those items which we believed had the greater risk of noncompliance with federal regulations, and of being unrelated to patient care. Therefore, the results of our analysis cannot be considered to be representative of the overall operations of the 21 providers included in our review.

Almost 75 percent of the unallowable general and administrative costs dealt with self-insurance and undocumented expenditures. The remaining 25 percent of unallowable costs fell into several categories including: personnel perquisites, marketing, social activities, donations, legal, consultants, and other miscellaneous groupings.

We found numerous instances of costs charged to Medicare for parties, liquor, golf club outings, and membership fees in social clubs that hospitals believe are allowable, but, have no relationship to patient care and, therefore, we believe are unallowable.

Some unallowable costs identified were explicitly unallowable and have resulted primarily from the providers' lack of internal controls over costs included in Medicare cost reports. We are also recommending that HCFA clarify its guidance to the providers regarding the allowability of costs.

Our audit focused on general and administrative and fringe benefit costs included in hospitals' Medicare cost reports. The effect that any unallowable costs would have on Medicare expenditures depends under which of the two methods a hospital is reimbursed.

The most common method of reimbursement is the Prospective Payment System (PPS). Today there are about 6,500 hospitals participating in the Medicare program. About 5,500 of these hospitals, or 85 percent, are reimbursed for inpatient care under PPS. We included 16 of these hospitals in our review as well as the costs associated with the corporate home office expenses for 2 of these hospitals.

Since hospitals reimbursed under PPS receive the same payment for a particular diagnostic related group (DRG) regardless of their costs, inappropriate general and administrative costs and fringe benefit costs have no immediate direct effect on Medicare reimbursement for inpatient services provided to Medicare beneficiaries.

Inappropriate overhead expenditures, however, do directly effect Medicare reimbursement for outpatient services and for services provided by excluded units of the PPS hospitals. Excluded units are psychiatric, rehabilitation, and alcohol/drug units of general hospitals.

The unweighted average immediate and direct effect on the Medicare program of unallowable and inappropriate expenditures on the 16 hospitals included in our review was about 5.75 percent.

The second method of reimbursement under Medicare is the reasonable cost method. Under this method, hospitals are reimbursed for inpatient services on the basis of reasonable costs subject to applicable target rate ceilings.

Hospitals falling under this category are psychiatric, rehabilitation, children's, long-term, and alcohol/drug hospitals. Since Medicare reimbursement to these hospitals is based on actual costs rather than a fixed payment rate, inappropriate costs have an immediate direct effect on their Medicare reimbursement.

We included in our review three hospitals that are reimbursed under the reasonable cost method and found the average Medicare participation rate was 60.46 percent; that is, 60.46 percent of the unallowable or inappropriate costs included on the Medicare cost reports by these hospitals were subject to reimbursement by Medicare.

Our results demonstrate a need for more explicit guidelines on the allowability of certain general and administrative costs and fringe benefit costs charged to the Medicare program.

The impact of the unallowable and otherwise questionable costs is reduced by the fact that the majority of participating hospitals are paid under a fixed price system—PPS. However, there remains a need for the HCFA to provide explicit guidelines on the allowability of certain general and administrative costs and fringe benefit costs even under the PPS system of payment.

There is too much reliance on the broadly defined cost concepts of reasonableness, relationship to patient care, and the "prudent buyer" concept, without explicit instructions on how these concepts should be applied to specific costs. Even some of the providers mentioned the need for clearer guidelines.

In our draft summary report, we recommend that HCFA revise the provider reimbursement manual to provide additional clarification on the allowability of specific types of general administrative and fringe benefit costs.

CONCLUSION

The Office of Inspector General in conjunction with HCFA continues to set ambitious goals to promote economy and efficiency in federal health programs. We believe that beneficiaries should receive quality care, that the integrity of the trust funds is maintained and that those individuals that defraud the department's programs be held responsible for their actions. We support the program safeguard activities of Medicare contractors and look forward to continued cooperation with the Department of Justice and state fraud control units. Adequate funding for establishing payment controls, audit oversight, case development, and investigative and prosecutorial activities are critical to the effectiveness of these efforts. We appreciate the interest the committee has in these areas and their continued support to promote our efforts.

I would be happy to answer any questions that the committee may have.

EXPENDITURES IN THE PAYMENT SAFEGUARD AREA

Senator HARKIN. Thank you very much, both of you, for your fine work and for your testimony.

Let us go back and let us set the stage here a little bit, for the record. And let us take a look at the charts we have.

Chart No. 1 over there on my far right, your far left, I believe—was that a chart that came with you from the IG's office?

Mr. REEB. Yes, sir.

Senator HARKIN. Would you explain that chart for me, please?

Mr. REEB. What it essentially lays out is the expenditures in the payment safeguard areas, the four areas that Ms. Brown referenced in her testimony, relative to the savings that have been realized from those activities.

And it essentially shows the investment as being relatively flat—it had some up and down periods—but then the savings are substantially greater than the investment itself.

Senator HARKIN. So this chart illustrates that for about every \$1 we put into the Payment Safeguards Program, we recoup for the taxpayers about \$14.

Mr. REEB. Yes, Senator.

Senator HARKIN. That is what that chart shows?

Mr. REEB. Yes, Senator.

Senator HARKIN. And is that money—again, I want to make it clear—that those savings are not ephemeral. Those are real savings? That is real money that is recaptured or saved?

Mr. REEB. Yes; most of it is, in fact, real money that is being returned; some of it is, in fact, being avoided through implementing corrective actions identified from the payment safeguard activities.

Senator HARKIN. So, for every \$1 we put in, we are saving the taxpayers about \$14. That is a pretty good return.

On what is being done in terms of reimbursing hospitals and corporate offices, alcoholic beverages, entertainment costs. Chart 2 has a whole list of different items there that are reimbursable.

Now, tell me about this chart. Who brought this chart? Is that yours, GAO?

Ms. JAGGAR. Yes, sir.

Senator HARKIN. Tell me about this chart over here, entitled, "GAO Review of Medicare Expenses, Case Study: Unallowable, Questionable and Unsupported Costs." Go through some of those items, and tell me what those are all about.

Ms. JAGGAR. This chart is taken from a report that was issued recently by our staff in the National Security and International Affairs Division. The chart illustrates the results of our review—we looked at \$2.6 million of charges that the Hospital Corporation of America submitted for payment to its fiscal intermediary.

Of those \$2.6 million in charges, we raised questions about—as you can see at the bottom of the middle column—\$1.06 million worth of those charges.

Senator HARKIN. Is that in one hospital? No.

Ms. JAGGAR. No; this is the Hospital Corporation of America, which is a \$5 billion a year organization. It is the corporate headquarters that submits the Medicare cost report.

And of that, they had about \$114 million that was included in the Medicare home office cost report. This amount of cost was allocated to hospitals; this is not for payment for physicians; it represents general and administrative costs. And of that, we looked at \$2.6 million worth of charges. As the IG did, we selected to review costs that warranted review, that seemed to be questionable.

Senator HARKIN. So then, you dug into those, and found out what they were?

Ms. JAGGAR. Right. We dug into those. And of the \$2.6 million, \$1.06 million seemed to us to be either unallowable, questionable or unsupported. So the column of unallowable, which totals \$549,000, is \$549,000 out of the \$2.6 million, that we looked at overall.

Senator HARKIN. So when I look at something like a 200 and—let us look at this. Foreign travel, \$53,657. This is just one corporation?

Ms. JAGGAR. Right.

Senator HARKIN. Could this be involved in other hospitals, other hospital corporations?

Ms. JAGGAR. The HCA submits its Medicare cost report, as do other hospitals and hospital corporations, using as guidance the guidelines put out by HCFA. The criteria for what should be reimbursable is fairly soft in some instances. The guidelines talk about using criteria such as reasonable, necessary, and related to patient care.

Senator HARKIN. Let me ask you this. Obviously, in their request for reimbursement from Medicare, they did not list foreign travel. Is that right? I mean, when they listed their administrative costs, did they list foreign travel?

Mr. DOWDAL. That does not come in as a specific item. It is categorized in a big group of items. And you get total numbers on the cost reports. You have to look behind the totals in order to see what the specific costs are.

Senator HARKIN. That is what I am getting at. So, when the request for reimbursement comes in from the—is this the, Hospital Corporation of America?—for administrative costs and other things, you said it was \$114 million, right? For 1 year?

Ms. JAGGAR. Yes.

Senator HARKIN. Buried in that are these items of foreign travel and alcoholic beverages and entertainment, and things like that, which—would the payment safeguard system be able to pick that up right away? Is there any way that it would kick that out from a computer, or not?

Mr. DOWDAL. Not without going and doing an audit. You have to do a cost audit to find those kinds of items; because what you will have is a couple of general accounts that end up in the cost report. And there will be an accumulation of all of these kinds of materials.

Now, the one on the foreign travel, that is pretty well accepted as being unallowable. They put it in anyway. Not too many foreign hospitals are treating Medicare patients, so it is a little hard to see where that would be related to the Medicare Program.

Ms. JAGGAR. Perhaps I could just clarify one thing?

Senator HARKIN. Pull that mike in a little closer, please.

Ms. JAGGAR. There are several different kinds of activities: Auditing of hospital cost reports is one activity; in addition, other payment safeguard activities, which we were referring to in our statement, have to do more with reviewing the actual claims by providers, sort of on a 1-on-1 basis, for care provided to beneficiaries.

So, when we are talking about these kinds of activities, we are talking about only one of the activities that are normally called payment safeguards. This is the one that comes under the old tra-

ditional term of auditing the cost statements of the hospitals or the hospital corporations.

Senator HARKIN. Well, I think you see what I am getting at here, is, here is one large corporation, putting in for a big amount of reimbursement. If they are burying this kind of stuff, what assurances do I have, or do the taxpayers have, that this is not being replicated by hospitals all over this country? Maybe not to this extent, but little bits here and there that add up in the aggregate to a lot of money.

Mr. DOWDAL. It is not only hospitals. It is also home health agencies and skilled nursing facilities and other kinds of providers.

Senator HARKIN. All health care providers. I did not mean to just single out hospitals, but all health care providers who are getting reimbursed by Medicare. What assurances do I have that this is not being replicated all over the country?

Ms. JAGGAR. You do not have any assurance that it is not being replicated. And that is part of the reason that we have recommended that the guidelines for what is allowable and what is not allowable be clarified, so that there is more specificity, as appropriate. We do not want to be overly specific. It is not the same to provide health services as it is to buy hammers, for example.

But there should be additional clarification and specification, so that there is less confusion and more clarity.

Mr. DOWDAL. And again, if you do not provide adequate funding for the audit function, having good clear regulations will not do you a lot of good either, without some way of enforcing them. And that is through the audit process.

Senator HARKIN. What—how would they ever put in for \$233,547 for scholarships? What is that all about?

Mr. REEB. We found a similar issue. That is GAO's number, from the HCA audit. We found a similar situation in a hospital in Pennsylvania; and it gets into probably the more difficult area in the general administrative costs, that is, determining what is a reasonable employee benefit, relative to providing necessary care to the patients.

And in the case of the university that we audited, the university-based hospital, they had \$561,000 in similar costs for dependent scholarships for employees of the hospital to attend the university, the associated university. And we do not believe that it has a direct relationship to providing patient care; therefore, it should be an unallowable cost, within the general administrative costs pool. And I think it is the same issue as GAO reported in the HCA audit.

Senator HARKIN. I have a list here of 21 health facilities that your office, the IG's office, inspected and found a grand total of \$47.4 million in unallowable costs.

Mr. REEB. Yes, Senator. These were 19 hospitals and 2 home offices, which were similar to the HCA, where the home office costs are not directly reimbursed, but rather, shared among the hospitals.

Senator HARKIN. How many health care facilities are there that participate in the Medicare Program, that get reimbursed?

Mr. REEB. There are about 6,500 hospitals that are reimbursed.

Senator HARKIN. How about other, home care, other?

Mr. DOWDAL. About 18,000 nursing homes, and I believe there are about 5,000 home health agencies.

Senator HARKIN. About 18,000 nursing homes; 5,000 home care agencies; plus 6,500 hospitals. About 30,000 total? Close? Ballpark? And you investigated 21?

Mr. REEB. Yes, sir; 21 hospitals.

Senator HARKIN. And out of the 21, we found \$47 million in unallowable costs?

Mr. REEB. Yes, sir.

Senator HARKIN. Can I extrapolate anything out of that?

Mr. REEB. We try not to do that, living with the GAO auditing standards. We are not allowed to extrapolate 21 against 5,000. But it was a fairly substantial number, relative to what we looked at.

The only thing, again, as Ms. Brown mentioned, is that we did look at cost centers and general ledger accounts where we thought we might find problems in travel, membership dues, fees that were paid for various things; and so they are more susceptible.

Senator HARKIN. I am going to put this in the hearing record, the list of these 21.

[The information follows:]

OFFICE OF INSPECTOR GENERAL—SCHEDULE OF UNALLOWABLE COSTS—FISCAL YEAR 1991
[Revised as of November 1993]

Hospital name	Physician support/recruitment	Donation/marketing/public relations	Legal	Fines and penalties	Consultants	Membership dues	Perquisites	Self insurance	Accounting errors	Undocumented costs	Miscellaneous	Total
Massachusetts General Hospital ..	\$6,402	\$34,299	\$17,011	\$2,800	\$50,991	\$64,175	\$330,119	\$15,000,000		\$16,891	\$5,161	\$15,527,849
New England Medical Center		5,100		98	60,000	82,040	25,084			4,602	475	177,399
Beth Israel		175,394	829	2,500			9,160					187,883
Lenox Hill Hospital		19,169		7,625			2,903				1,775	31,472
Medical College of Pennsylvania ..							207,933					207,933
Thomas Jefferson University Hospital		891,211				16,488	758,031		\$1,643,120	515,270	377,370	4,201,490
Albert Einstein Medical Center		346,548					34,500					381,048
Moss Rehabilitation Center					17,034		39,511			6,762	14,224	77,531
Allied Services—Home Office		113,191					32,245				40,229	185,665
Allied Institute		6,300										6,300
The John Heinz Institute		9,945					5,442					15,387
Humana Inc.—Kentucky		129,805	252,764			3,995	89,859	10,596,663	9,403,437		259,961	20,736,484
Baptist Hospital	81,997	337,837	8,192		38,474	2,366	32,147				2,500	503,513
Parkway Hospital	12,484	616	1,105,212	7,519	15,570		27,561				91,598	1,260,560
Northwestern Memorial Hospital ..	1,839,026	146,208	1,890		10,252	14,940	284,072				6,840	2,303,228
Memorial Medical Center		41,151				1,755	165,753				669	209,328
Humana Hospital—San Antonio ..							82,396				1,147	83,543
North Kansas City Hospital		1,050			7,000		265,535					273,585
St. Joseph Hospital		408,009				896	154,674		909			564,488
Roseville Hospital		208,006	8,911	4,581			25,635					247,133
Virginia Mason Hospital		203,697	4,222	126		1,357	2,617				16,703	228,722
Total	1,939,909	3,077,536	1,399,031	25,249	199,321	188,012	2,575,177	25,596,663	11,047,466	543,525	818,652	47,410,541

Senator HARKIN. This is public, right? There is nothing private about this list?

Mr. REEB. No; the list itself has not been in a report, but each report has been issued.

Senator HARKIN. I think we ought to start pointing out to the public who these people are. They are using taxpayers' dollars. I notice here on this list of 21, most of them had to do with perquisites. Some of them just seem to be almost egregious.

Mr. REEB. Some of the large dollar items, Senator, involved more along the accounting, financial management issues; perhaps not quite as visible as in alcohol or entertainment type expenses, but in fact, are costs that we consider to be equally as inappropriate to be submitted for reimbursement. And those are in the columns above.

Senator HARKIN. For example, let me read some of the list of the items that you found, especially these 21. I do not know which hospital, or which one it was. Just some of the items that were found here [reading]:

Clocks, watches, and bowls for employees and friends, \$10,215.

It is amazing. How about:

A leased Chrysler Fifth Avenue for the president, a leased Accura Legend for the executive vice president, a leased Buick Regal for the vice president, total \$15,702.

Weekend in resort, gas purchases; Executive's car washed. Trip to Asia, to promote hospital referrals, \$5,000.

Amazing.

Air fare and trips for executives' spouses?

How about a:

Trip to Italy, to inspect a sculpture, \$2,433?

Well, I do not know. I could go down this list, this is pretty revealing.

Sporting events, \$4,200. Out-of-court settlement and parking fines, \$4,581?

I guess you just park illegally, and Medicare picks up the tab, right?

How about a:

Golf tournament, open only to the executives? TV advertising campaign, \$191,000?

What is that all about? Do you have any memory of that at all? That is a specific item, I just happened to pick that.

Mr. REEB. I do not remember that specific one. But a number of the promotional items that we felt were unallowable were not examples where you are trying to put forth that you do certain procedures within the hospital, or you do quality work, or whatever. You are really trying to entice patients to go to your hospital. And that is an unallowable cost.

Senator HARKIN. Does any of this relate to patient care?

Mr. REEB. We do not believe so.

Senator HARKIN. The \$191,000 for a TV advertising campaign really does not relate to patient care.

Ms. BROWN. Mr. Chairman, if I could mention. I am new at HHS, but previously I served as inspector general of three other agencies: Department of Interior, NASA, and Department of Defense.

I was rather shocked to find that, not only were some of these things quite extreme—as those you are pointing out—but the most difficult thing to work with in the Medicare area is the fact that there is no specificity within the regulations. And therefore, even when we find things that are outlandish, there is no way we could bring charges successfully.

I think some of the kinds of things you mentioned were deliberate, and the kind of offenses that we should seek prosecution. But with this vagueness, the most we can do if we find them, is to get the money back. And even there, in those gray areas, there is difficulty at times in doing that.

So I do think that it makes a very, very good case for getting the kind of specificity that you are talking about.

Senator HARKIN. But these are definitely unallowable. These are not even questionable, are they?

Mr. REEB. In some of the areas, when you get into the perks given to employees, it becomes hazy as to what is allowable, and what is not allowable. A lot of the other items were absolutely unallowable, Senator.

Ms. BROWN. But there is not necessarily a penalty. And to keep people from at least trying the system and putting in everything, and then depending on audit to reverse that, without a severe penalty—

Senator HARKIN. Are you telling me that this list of 21 from which I drew some of these examples, that if they put in there, a trip to Asia, which is clearly unallowable, you mean there is just no penalty for that?

Ms. BROWN. Well, we have not been able to successfully prosecute one case where we felt there was deliberate addition of unallowable cost. So we can get money back where it is clearly unallowable, but a prosecutor will not take that case; because there is not enough clarity in what is allowable and unallowable.

Senator HARKIN. OK. So what do we need to clarify? You have been an inspector general in a couple of other agencies. What do we need?

Ms. BROWN. I think your chart up here, based on the GAO review, that shows the difference in Medicare allowability, what is under the FAR, the Federal acquisition regulations, or OMB Circular A-21, demonstrates very well the kind of specifics you need to put into the regulation or the guidelines. These things cannot be added; if they are, there is definite word that they have been on record and it is the responsibility of the provider to see to it those kinds of things do not creep in. If they do, we can penalize them.

Senator HARKIN. I see. So, for example, under entertainment, which is listed on this chart—in Medicare it is not specifically mentioned, but under FAR and under Circular A-21, both of those specifically disallow those?

Ms. BROWN. That is right. Yes, sir.

Senator HARKIN. Do other reimbursable agencies that get reimbursed from the Federal Government, do they operate under FAR and A-21?

Ms. BROWN. A-21 is for the universities, and so it is very specific to that. Almost all contracts, perhaps all contracts, are under the Federal acquisition regulations.

So in that area, if a contractor ever put those kinds of costs in as part of their overhead, clearly it would not only be an offense, where you got your money back; but if you could show that they deliberately did that, and took no precautions against it, you could prosecute them and penalize that organization or the individuals involved, for taking that liberty.

Mr. REEB. Many of the providers, the hospitals we were at, mentioned the fact that because it is not specifically unallowable in the provider reimbursement manual, which they use as their bible more or less, they spend the money and submit it as a reasonable cost and expect payment.

So, it is similar to what GAO mentioned earlier, that because you do not really have enough money to do all the auditing that you would really like to do with the fiscal intermediaries over these providers and because you are trying to audit things like capital costs that are much bigger dollar items, the general administrative type costs can slip through. And if you submit the cost because you spent the money, it is almost catch me if you can.

Mr. DOWDAL. Again, Mr. Chairman, Medicare's rules for payment are very specific in some cases, and there are many things that are not allowable under the Medicare regulations that are allowable under the Federal acquisition regulations. In this case, we have an area that does not have much concentration in the regulations or the manuals on it, and we have pointed out that if Medicare would look at the other sets of regulations, it could extract from them the items that are covered in the general and administrative area, and put those into the Medicare regulations.

Senator HARKIN. But I assume we would have to do that legislatively, would we not?

Mr. DOWDAL. HCFA could do that on its own initiative. It has the authority to set the rules for what costs are reimbursable under Medicare.

Senator HARKIN. So, you are saying HCFA has the legislative authority to go ahead and do that right now?

Mr. DOWDAL. Right.

Senator HARKIN. He could go ahead and apply the FAR or A-21 to these types of items, right?

Mr. DOWDAL. HCFA could take the requirements in the FAR and make them part of the Medicare requirements for these particular items, and HCFA has the authority to do that without any further legislation.

Now, HCFA does not apply all of the Federal acquisition regulations to Medicare and it probably would not be a good idea to just substitute one for the other, but HCFA can take the good parts of the FAR. Where HCFA has weak areas in its regulations, they should consider putting FAR requirements in, and that is basically what we recommended.

Senator HARKIN. Very good. Now, look at the last line on that chart. It says advertising is unallowable in all three cases. Now, Mr. Reeb, I picked out one item here out of this list from these 21 hospitals and I mentioned TV advertising campaign, \$191,142, and you said it had nothing to do with patient care.

Well, if that is unallowable, are you saying that this is one hospital that put that in or is that more than one? That \$191,000, is that aggregate do you know?

Mr. REEB. I do not know off hand, Mr. Chairman.

Senator HARKIN. I am told it was just one. Now, if that is unallowable, and this is not a gray area, is it? It is not a gray area.

Mr. DOWDAL. There are certain kinds of advertising that are allowable, so they will take everything that they do in the advertising or a big part of what they do in advertising and stick it in, and wait and see if somebody will look and disallow. Specific kinds of advertising that are not done very much, but they are to let the public know that you are a hospital and your location or address, that is all right. Putting something in the phone book I guess is one of the ones I can remember.

But when you start trying to solicit patients through advertising on TV or the radio or whatever, or sending out mass mailings trying to get more patients to come in, that is specifically unallowable. What they do is they try to merge the two together.

Senator HARKIN. But I am saying that the people who, for example, run this health facility had a handbook and they were aware that this was unallowable, and they put it in anyway. Are you telling me no one is going to be prosecuted? Can they be prosecuted?

Ms. BROWN. We found that, although in some cases there was a likelihood that they could be prosecuted, it was unlikely to be successful to the degree that we could get a prosecutor to take the case. So, we have not successfully prosecuted any cases. And one of the reasons is the vagueness of the guidelines, making it difficult to prove a deliberate addition of some of these more flagrant types of charges of the type you mentioned—

Senator HARKIN. Well, for example, in your written testimony which you did not cover in your verbal presentation, on page 7 of your written testimony, Ms. Brown, you said that an OIG review of critical laboratory services showed that the Medicare Program pays twice the amount for laboratory tests than other payers.

These reviews led to the identification of schemes in which laboratories would manipulate physicians into ordering additional, medically unnecessary tests whenever they ordered a basic automated chemistry panel. We found instances where laboratories would charge physicians 65 cents for a test and bill Medicare for the same test between \$12 and \$19.

You say and I quote:

The Department of Justice is very active in prosecuting these cases. In one of the largest settlements in recent history, National Health Laboratories Inc., paid back \$100 million to Medicare and \$10.4 million to State Medicaid Programs based on the joint investigative and audit work of our office and the Department of Justice. In addition, the corporation paid a \$1 million criminal fine, and the corporation's president paid a \$500,000 criminal fine.

That is all well and good. Did anybody go to jail?

Mr. REEB. Yes; I believe that either the CEO or the president did spend several months in jail.

Senator HARKIN. Good. How about the one on the laboratory tests. Is that proceeding right now?

Mr. REEB. That was the same case, Mr. Chairman.

Senator HARKIN. You said they are active in prosecuting these cases. Are these closed cases?

Ms. BROWN. Those are in a different category. These are schemes to defraud, and they are not the same category of cases where a facility has added costs that are unallowable or appear to be marginal. And those are the ones that we have not been able to do anything about.

Senator HARKIN. Is that just because the Department of Justice will not prosecute? Have you turned them over for prosecution?

Ms. BROWN. In one case, which we felt, was a good solid case for prosecution, the Department of Justice rejected that case. Therefore, now we are not working on these cases while there is not enough specificity in the regs or the handbooks; we are not approaching it as a prosecutable offense.

We are approaching them as one where we are trying to get the money back and get clarity. But that does not mean we are not actively prosecuting and pursuing these obviously criminal schemes where they are defrauding the Government and the people who they are providing services for.

Senator HARKIN. They are obviously criminal schemes but, I mean, when people put in for items which are totally unallowable it seems to me that they make a conscious decision to do that. This is not something that is done unconsciously.

Ms. BROWN. That is my concern, too, sir. But that is a much harder case to prove and that is why I am supporting your position that there should be greater clarity.

Senator HARKIN. At a minimum that is what we ought to do. Again, let me look at this list here. I notice one item that just sticks out at me like a sore thumb here, and this is from Humana Inc., in Kentucky, an item listed here of self-insurance, \$10.5 million, and that is not an allowable item.

Mr. REEB. Yes, Mr. Chairman. They set up a self-insurance fund for malpractice expenses. Medicare allows self-insurance funds if in fact you contact a fiduciary that acts on you behalf and you pay into the fund.

They set up a \$15 million allowance for malpractice expense and actually only incurred a little over \$4 million in malpractice expenses. So, the difference between their actual \$4 million, which we gladly participate in on the Medicare Program and the \$15 million is an unallowable expense.

They do not really agree with that. They believe that they should have the right to set up self-insurance funds for the future potential of having these cases come up that were in this particular cost reporting period.

Senator HARKIN. I do not notice any of the other providers listed self-insurance.

Mr. REEB. No; it is a big corporation.

Senator HARKIN. Here is Massachusetts General Hospital. \$15 million self-insurance. Again, the same thing?

Mr. REEB. That is a different issue. But again, on their part, it is one if you are not telling me I cannot do it I will submit it, and then you have to tell me you are not going to accept it. And it involves the change in financial reporting under the Financial Accounting Standards Board statement 106 about recording future

health expenditure projections on your financial statements from a couple of years ago. And this \$15 million represented anticipated expenses for their employees in the future.

But again, because it is not funded Medicare will pay their fair share of these sorts of costs if in fact you incur an expense or if in fact you set aside moneys. In this case they did not. The requirement is merely that you show it in your financial statements, not that you necessarily set aside funds.

So, while the corporation does not agree with us, the fiscal intermediary did, but we understand that Massachusetts General is going to or has appealed this expense.

But again, every hospital has this reporting requirement problem, but they are the ones that test the waters, if you will.

Senator HARKIN. Well, I can understand that there are gray areas. People do not know, and that is why we need to have them clarified better. But in some of these which are clearly unallowable, it would seem to me that some vigorous prosecution might be in order to send a signal. That is not your bailiwick. I should talk to the Justice Department about that one, I guess.

I find some of these items are just mind boggling. Tiffany pitchers for hospital executives, \$14,912, and this all comes out of the health care dollar.

Ms. JAGGAR, I am pleased to see from your testimony that GAO strongly supports legislation that would permit increased appropriations for Medicare contractor staffing and performance of payment safeguard activities without necessitating cost cuts, spending cuts elsewhere. Again, your example, \$10 spent saves \$140—1 to 14 savings.

However, even with that no credit is currently given for the savings even though they are very real savings. I mean, these are real, hard dollars. So, no credit is given for that while the \$10 is counted as an increase in spending under my appropriations subcommittee.

Have you seen the legislation that I have introduced, the Medicare Program Protection Act? Are you aware of that?

Ms. JAGGAR. Yes, sir; I have seen that.

Senator HARKIN. Is this the type of legislative remedy you had in mind, to remove the disincentive to adequate funding of payment safeguard activities?

Ms. JAGGAR. We think that it accomplishes the objectives that we are mutually discussing here. This kind of opportunity has been set up for the IRS to allow them to avoid a similar kind of situation. It is difficult for HCFA and the Congress to pursue the safeguard activities by increasing the funding because it is part of the administrative expenses subject to the Budget Enforcement Act.

Your proposal enables HCFA to achieve the savings and make the investment that will help realize the return for the American tax payer by going after the fraud and abuse and the mismanagement of the Medicare Program without having to decrease funding in other areas.

Senator HARKIN. Ms. Brown, I think you indicated on terms of using FAR and A-21, and perhaps this might be out of your bailiwick, but do you have any thoughts on that type of legislation to provide that we would count the money saved as well as the money spent?

Ms. BROWN. I do not think that Medicare ought to have identical lists as those found in either A-21 or the FAR, and those two, of course, are not identical. But I think that we can point to those as examples of greater clarity. And I would prefer to see HCFA, actually, with their knowledge and experience to go through and add that clarity.

Senator HARKIN. Well, I am sort of asking GAO a policy question. Maybe I should not ask you that question since you are in the IG's office, and I will leave it at that with the GAO.

Well, Inspector General Brown, there is legislation pending that would basically say that the credit would be given for the savings that we get from the payment safeguards program, that would be listed as savings as well as the money that is counted as an expenditure. And I wondered, would that be helpful in any way in terms of trying to get the proper amount of money that is needed for the payment safeguards program?

Ms. BROWN. Yes, sir; I believe that efforts to connect the cost of taking these actions with the recovery rate so that we could go ahead and do the work where it was necessary and it was truly cost effective would be very, very helpful.

Senator HARKIN. I appreciate that. Let me just get to one other thing.

HOSPITAL CORPORATION OF AMERICA

The chief executive officer of the Hospital Corporation of America [HCA] reportedly earned \$127 million in 1991, many times greater than the company's profit that year. According to the business press this was also the largest compensation paid to any CEO in the entire country for that year.

Does not the executive compensation of this magnitude just drive health care costs upward since, again, the company will eventually have to recover these costs? They have got to come out of something, and they come out of the health care dollars.

I would perhaps ask HCFA this question. Do you recommend a limit on Medicare payments to hospitals that might pay their CEO's an excess of a certain amount of money? I mean, how much is a CEO worth? \$1 million a year? It seems to me when you are getting up to \$100 million a year for a CEO that is fine. I mean, if they want to sell us widgets or McDonalds, they can pay them whatever they want to pay them.

Mr. DOWDAL. Medicare does basically have that rule. This compensation would not have been put into the cost report. It resulted from the leveraged buy out of the company with the stock for the CEO or the stock options and that kind of stuff.

Medicare did not pay it but somebody, as you are saying, somebody did pay it. Somebody paid \$300 million in interest to cover the leveraged buy out and that obviously has to come out of the money that HCA got from patient care. Now, Medicare has got a rule and did not participate in that from the Medicare point, and Medicaid should not have either. But when you pay your FEHB premium you participated in it and so did I.

Senator HARKIN. Well, I wonder how much of that might have also been put into the rubric of administrative costs, for example, which Medicare does in fact reimburse for.

Mr. DOWDAL. Well, that kind of stuff would never be allowed in Medicare, and if it showed up, Medicare would probably find it because that would be so dramatic. And that definitely would not be allowable costs under Medicare.

Senator HARKIN. Well, I know it would not be an allowable cost, but it would be something that would drive up all other costs. It would drive up the administrative costs and that would be reimbursable.

Ms. JAGGAR. One of the reasons we are concerned about such large sums is that it does throw into question the integrity of the health system, and it makes the public concerned in a broad way about what is going on. And there are many people, as you are very well aware, who are working very hard to assure the public that the Medicare Program and that the health industry and the health system in the United States is an effective one, and one that gives the public a good benefit. And such sums raise a question in the public's mind and are very dangerous as a result.

Senator HARKIN. Well, I appreciate the fine work that you are doing, both the IG's office and GAO. I think we may be calling on you to do some more in the near future about looking at some of these items in greater depth to find out just whether or not some of these people ought to be referred for prosecution or not, especially when it is very clear that it is unallowable and they put it in anyway.

And I am somewhat afraid that what happens is that, well, they pay the money back. OK, fine, they pay the money back, and just go around and try it again. It is sort of like disciplining our children, right? You say, do not take those cookies anymore, but if you do not discipline them they take them again. So, it seems to me there has got to be some discipline.

Do you have anything else you want to add before I excuse you?

Ms. BROWN. No, sir; thank you.

Senator HARKIN. Well, thank you very much again. Thank you for the fine job you did in uncovering this terrible amount of waste in the Medicare reimbursement system. Thank you.

STATEMENT OF CAROL WALTON

Our next panel is Carol Walton, Director of the Bureau of Program Operations for the Health Care Financing Administration.

Ms. Walton, thank you very much for being here this morning. I have your written statement; it will be made a part of the record, in its entirety. And you can introduce the people who are with you, and their positions. Please proceed.

INTRODUCTION OF ASSOCIATES

Ms. WALTON. Thank you, Mr. Chairman, and members of the subcommittee. I am Carol Walton, Director of the Bureau of Program Operations at HCFA. I am accompanied today by Charles Booth, Director of the Office of Payment Policy; and Linda Ruiz, Acting Director of the Office of Medicare Benefits Administration.

We are pleased to testify today, regarding the Medicare payment safeguards. The Medicare Program provides the payment of health care services for more than 36 million beneficiaries. HCFA admin-

isters the program through contracts with fiscal intermediaries and carriers that process the Medicare claims.

In fiscal year 1993, the contractors processed over 700 million claims for approximately 600,000 providers, resulting in benefit payments of over \$143 billion.

The challenge for HCFA has been to apply our constrained financial resources in a way that will permit processing of claims within statutory time limits, while maximizing our ability to safeguard Medicare payments.

The Medicare payment safeguards comprise four activities: Medical review; insuring benefit integrity; cost report audits; and Medicare secondary payer program.

MEDICAL REVIEW

The Medical review activities guard against inappropriate payments, by ensuring that the care provided to beneficiaries is medically necessary and appropriate. Our fiscal year 1994 budget includes \$120.6 million for medical review, with an expected return on investment of 7 to 1.

To achieve maximum benefit for the dollars spent, the Medicare contractors focus the medical review activities on services with the highest probability of being medically unnecessary. Services to be reviewed are identified through the analysis of utilization data, the use of medical review guidelines, and applying prepayment screens.

In fiscal year 1993, contractors were given additional funding to acquire software, hardware and personnel that were needed to improve the focused medical review program.

Carrier medical review is moving toward an emphasis on increased education of providers. The goal is not only to deny inappropriate or medically unnecessary claims from a provider, but also to educate the providers on what is medically necessary, and what is not covered by Medicare. These efforts will enable providers to bill Medicare correctly the first time.

BENEFIT INTEGRITY

HCFA is also strengthening efforts to detect and deter Medicare fraud and abuse. HCFA's benefit integrity initiatives will identify providers who knowingly submit inappropriate claims. Our fiscal year 1994 budget includes \$24.8 million for benefit integrity.

HCFA has established Medicare fraud units at most contractor sites. The goal of these units is to detect fraud and abuse and to develop cases for referral to the Office of the Inspector General for further action.

In addition, HCFA funded a fraud and abuse information network at a number of our contractors last year. This major initiative facilitated the sharing of information on detection and deterrence activities across the Nation, with the goal of identifying fraud cases with a potentially national scope.

HCFA is also instituting National fraud and abuse initiatives to address specific issues which have come to our attention. These initiatives combine fraud and abuse action with programmatic changes in our operations and our policies, which may be needed to stem the abusive practices.

COST REPORT AUDITS

The third component of Medicare payment safeguards is the auditing of provider cost reports. Our fiscal year 1994 budget includes \$141.9 million for audit activities, with an expected return on investment of 8 to 1.

To better use limited funding, HCFA has worked with the contractors to establish automated systems for various phases of the audit process. Some of the intermediaries have developed sophisticated software programs that enable them to do comparative analyses across cost reporting periods, to better focus the audit efforts, and to detect aberrances in reporting.

HCFA recently sent instructions to the contractors, implementing a new audit process that can build on the automated systems' abilities to identify and target high-risk areas for audit. The new initiative enhances communications between the providers and the auditors to clarify the scope of an audit, to identify the key documentation, and to resolve issues in a timely manner.

MEDICARE SECONDARY PAYER PROGRAM

The Medicare Secondary Payer Program [MSP] is the fourth major component of our payment safeguards. MSP activities are designed to ensure that Medicare pays second in situations where a beneficiary has other insurance which should pay first for services billed by a provider. Our fiscal year 1994 budget includes \$101.2 million for Medicare secondary payer activities, with an expected return on investment of 36 to 1.

A major MSP initiative is the IRS/SSA/HCFA datamatch project, which matches employment records to identify situations where Medicare pays secondary to another insurer.

Another important MSP activity is the initial enrollment questionnaire [IEQ]. This enrollment questionnaire will be sent to all beneficiaries as soon as they enroll in the Medicare Program. The questionnaire will provide HCFA with information needed to ensure that, if Medicare should be the secondary payer, it will be the secondary payer right from the start. We anticipate a contract to distribute this questionnaire will be awarded this coming spring. The RFP is anticipated to be on the street today, I believe.

MEDICARE TRANSACTION SYSTEM

To streamline Medicare claims processing, HCFA has begun the Medicare transaction system initiative, the MTS initiative. The Medicare transaction system will allow processing of claims at an optimal number of sites, with one standard processing system.

We believe this will increase the efficiency and the accuracy of claims processing, and will result in much-improved oversight of Medicare funds. We solicited proposals for a contractor to design and develop the MTS in September 1992, and we anticipate awarding a contract this December.

HOSPITAL OVERHEAD COSTS

Finally, I would like to address specific issues raised by the GAO and the Department's Office of Inspector General concerning the allowability and payment of hospital overhead costs.

Medicare payment principles recognize as necessary and proper, all provider costs related to services furnished to Medicare beneficiaries. Necessary and proper costs usually reflect common and accepted hospital practices throughout the industry. Implicit in the intention that only reasonable costs be recognized, is the expectation that a provider will seek to minimize its costs to those that would be paid by a prudent buyer.

The findings of the two reports identify some general and administrative and some fringe benefit costs—such as alcoholic beverages at employee functions, lobbying costs, charitable contributions made by providers—which we agree do not constitute allowable costs. Other costs identified in the reports—such as employee subsidized lunches and employee awards—we believe are allowable.

CONCLUSION

In conclusion, let me emphasize that safeguarding the Medicare payments is an essential part of HCFA's responsibility. We have started some major enhancements and accomplished a lot in the past year. We look forward to working with you, as we initiate some further improvements.

We are very excited about the Medicare transaction systems, and the possibilities for truly consistent and accurate claims processing, which will allow the carriers and intermediaries a much greater ability to focus on optimal payment safeguard techniques.

PREPARED STATEMENT

Additionally, the Medicare transaction system will provide reliable standard reports, which will facilitate HCFA's oversight and management of the payment safeguard activities. Likewise, we are encouraged by the National Performance Review themes of fostering healthy competitiveness in contracting, to assure we get the best value in our Medicare contracts.

We would be happy to respond to any questions you may have. [The statement follows:]

STATEMENT OF CAROL J. WALTON

Mr. Chairman and members of the Subcommittee, I am Carol Walton, Director of the Bureau of Program Operations. I am accompanied by Charles Booth, Director of the Office of Payment Policy, and Linda Ruiz, Acting Director of the Office of Medicare Benefits Administration. We are pleased to testify today regarding HCFA's payment safeguard activities.

BACKGROUND

The Medicare program provides for the payment of health care services for more than 36 million beneficiaries. HCFA administers the program through contracts with fiscal intermediaries and carriers that process Medicare claims. In fiscal year 1993, intermediaries and carriers together processed over 700 million claims for approximately 600,000 providers, resulting in benefit payments estimated at \$143.2 billion.

The challenge for HCFA has been to apply the financial resources provided through the appropriations in a way that will permit the processing of claims within

statutory time limits, while at the same time maximizing its ability to safeguard Medicare payments, during an era of constrained contractor budgets.

Four areas comprise HCFA's payment safeguards program: medical review, benefits integrity, audit, and Medicare secondary payer. These activities also are supported by efforts to improve coordination of benefits.

MEDICAL REVIEW

Medical review activities guard against inappropriate benefit payments by ensuring that the care provided to beneficiaries is medically necessary and appropriate. Our fiscal year 1994 budget includes \$120.6 million for medical review with an expected return on investment of seven to one. To achieve maximum benefit for dollars spent, HCFA is implementing the focused medical review initiative. This initiative will reduce provider hassle, identify areas most likely to have problem claims submitted by providers, and educate providers to bill correctly.

Contractors focus their medical review activities on those areas with the highest probability of medically unnecessary services. Services to be reviewed are identified through the analysis of utilization data, development of medical review policy with input from the medical community, and the use of "focused" pre-payment screens that select specific claims for review. Beginning in fiscal year 1993, contractors were given additional funding to acquire software, hardware, and personnel needed to implement focused medical review. We have found that focused medical review yields the highest return for the money invested by targeting areas that produce the highest savings. HCFA is actively researching ways to improve data analysis in order to be able to better identify areas for review, education, and investigation of fraud and abuse.

Carrier medical review is moving toward an emphasis on increased education of providers. The goal now is not to simply deny inappropriate or medically unnecessary claims from a provider. In fact, emphasis solely on claims denial can provide a disincentive for proper medical review by encouraging overzealous and perhaps inappropriate denial of claims. Instead, we want to educate the provider on what is medically necessary and what is not covered by Medicare. These efforts will enable providers to bill Medicare correctly the first time.

BENEFITS INTEGRITY

HCFA is strengthening efforts to detect and deter Medicare fraud and abuse. HCFA's benefits integrity initiatives will identify providers who knowingly continue to submit inappropriate claims. Our fiscal year 1994 budget includes \$24.8 million for benefits integrity.

HCFA has established Medicare fraud units at most of its contractor sites. The goal of these units is to detect fraud and abuse and to develop cases for referral to the Office of the Inspector General for further action, including prosecution and the imposition of sanctions. The medical review and fraud and abuse staffs work closely together to share information and ensure appropriate action is taken.

In addition, HCFA funded a fraud and abuse information network at a number of contractors in fiscal year 1993. This major initiative facilitated the sharing of information on detection and deterrence activities across the nation, with the goal of identifying fraud cases with a potentially national scope.

HCFA also is instituting national fraud and abuse initiatives to address specific issues which have come to our attention. These initiatives combine fraud and abuse actions with programmatic changes in operations and policy which may be needed to stem abusive practices.

For example, in the wake of the National Health Laboratory settlement with the Federal government, HCFA formed a clinical laboratory task force consisting of HCFA, the Department of Justice, and Inspector General representatives. This task force is developing short and long term remedies to problems associated with billings by clinical laboratories. HCFA also just completed a task force effort addressing rehabilitation therapy billing practices, resulting in significant improvements in policy and operational procedures. Moreover, HCFA just completed a pilot study to improve its ability to detect and deter abuses in the home health benefit.

PROVIDER AUDIT

The third major component of the Medicare payment safeguards program is the auditing of provider cost reports. Our fiscal year 1994 budget includes \$141.9 million for audit activities with an expected return on investment of eight to one.

To better use limited funding, HCFA has worked with its contractors to establish automated systems for various phases of the audit process. Some of the

intermediaries have developed sophisticated software programs that enable them to do comparative analysis across cost reporting periods to better focus their audit efforts and to detect aberrancies in reporting. HCFA recently sent instructions to its contractors implementing a new audit process that can build on the automated systems' abilities to identify and target areas for audit. This new initiative enhances communications between providers and auditors to clarify the scope of an audit, to identify key documentation, and to resolve issues in a timely manner.

In addition, HCFA has developed systems which produce information for audit, facilitate future audit decisions, and aid in the evaluation of the effectiveness of the audit process. Future plans include limiting the number of standard field audits and increasing the number of special audit initiatives which focus on high risk issues.

MEDICARE SECONDARY PAYER

The Medicare secondary payer (MSP) program is the fourth major component of payment safeguards. MSP activities are designed to ensure that Medicare pays second in situations where a beneficiary has other insurance which should pay first for services billed by a provider. Our fiscal year 1994 budget includes \$101.2 million for Medicare Secondary Payer activities with an expected return on investment of 36 to 1.

A major MSP initiative is the Internal Revenue Service/Social Security Administration/Health Care Financing Administration Data Match Project, which matches employment records to identify situations where Medicare is secondary to another insurer.

Another important MSP activity is the Initial Enrollment Questionnaire (IEQ) initiative. In the past, Medicare has been forced to first pay a claim, then recover the amount of any mistaken payment, a generally inefficient process. The IEQ will be sent to all beneficiaries as soon as they enroll in the Medicare program. The questionnaire will provide HCFA with the information needed to ensure that if Medicare should be the secondary payer, it will be the secondary payer right from the start. We anticipate the contract to distribute the IEQ will be awarded next Spring.

THE MEDICARE TRANSACTION SYSTEM

HCFA conducts an intensive monitoring program of the Medicare contractors, which includes heavy emphasis on payment safeguards activities. However, a program which involves over 80 separate contractors that use 14 different systems to process claims poses some inherent administrative problems.

HCFA has, therefore, begun the Medicare Transaction System (MTS) initiative. The MTS would allow the processing of claims at an optimal number of sites with one standard processing system. We believe this initiative would increase the efficiency and accuracy of claims processing and would result in much improved oversight of Medicare funds. We solicited proposals for a contractor to design and develop the MTS in September 1992, and anticipate awarding a contract this December.

HOSPITAL OVERHEAD COSTS

Finally, I would like to address specific issues raised by the General Accounting Office (GAO) and the Department's Office of Inspector General (OIG) concerning Medicare payment of hospital overhead costs for services provided in the outpatient setting. Both organizations reported that certain hospitals were including items on their Medicare cost reports which they believed should not be allowable under the Medicare program. They also indicated that more specific policies and guidelines are necessary to guide hospitals and auditors as to what costs are not allowable.

Medicare payment principles recognize as necessary and proper all provider costs related to services furnished to Medicare beneficiaries. Necessary and proper costs related to patient care are usually costs which reflect common and accepted hospital practices throughout the industry. Implicit in the intention that only reasonable costs be recognized is the expectation that a provider will seek to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer would pay.

The findings of the two reports identify some general and administrative and fringe benefit costs such as alcoholic beverages at employee functions, provider lobbying costs, and charitable contributions made by providers that we agree do not constitute allowable costs. Some other costs identified in the reports such as employee subsidized lunches and employee awards we believe are allowable.

Our contractors have not yet completed a formal audit of these hospital cost reports in question. However, I can assure you that we plan to make an in-depth anal-

ysis of the GAO and IG reports and our contractors, audit findings and recommendations. Based on this analysis, we will revise the Provider Reimbursement Manual to address specific categories of general and administrative and fringe benefit costs in order to provide better guidance to hospitals and other providers and intermediaries concerning the allowability of costs.

CONCLUSION

In conclusion, let me emphasize that ensuring Medicare payment for only valid and necessary medical services and costs associated with those services is an essential element of HCFA's responsibility. HCFA continually works to improve our systems and operations to efficiently accomplish the primary function of paying the providers that serve our beneficiaries, while targeting scarce resources on safeguard initiatives that protect against waste and abuse of Medicare funds. We are proud of the accomplishments we have made in this area during the past few years and look forward to working with you as we initiate further improvements.

We would be happy to respond to any questions that you may have.

ALLOWABLE COSTS

Senator HARKIN. Thank you very much, Ms. Walton. Let me refer to your written statement. I was following through here. You said in your verbal statement that some costs identified in the reports, "such as employee subsidized lunches and employee awards, we believe are allowable."

How about scholarships for employees' children?

Ms. WALTON. Mr. Booth is the expert in this area, and I will let him answer.

Mr. BOOTH. Good morning, Mr. Chairman, thank you. What we have done historically is look at the total compensation package for the employees, as opposed to looking at individual items.

If, for example, the hospital pays lower than average salaries, but has other fringe benefits, one of which might be scholarships for their employees, we have not found that unallowable.

But again, we want to look at the total compensation package, from one hospital to another. I would not say, per se, that that is necessarily an unallowable cost.

The other point that needs to be made, particularly looking at the GAO and the IG figures, is that these are the total charges for the particular activities. This does not represent what Medicare would pay. For example, based on GAO's figures, the \$233,000 for the scholarships would translate to something in the neighborhood of \$10,000 in Medicare payments.

Senator HARKIN. I am sorry, say that again?

Mr. BOOTH. The \$233,547 on this chart, that is showing up as scholarships, would translate to approximately \$10,000 in Medicare payments.

Senator HARKIN. Oh, you are saying that this example—they did not put in for \$233,000 to be reimbursed by Medicare? They put in for \$10,000. Is that what you are saying?

Mr. BOOTH. Yes, sir; they put in for \$233,000 as the total cost of scholarships. But when you look at Medicare's percentage of payments on a reasonable cost basis, it translates to approximately \$10,000.

Senator HARKIN. Mr. Booth, my question is this: Did they put in for \$233,000, to be paid for by Medicare?

Mr. BOOTH. No.

Senator HARKIN. Thank you.

Mr. BOOTH. Well, no. The problem is that they put \$233,000 on their cost report, saying that is their total cost. The Medicare share of that, which they knew when they put it in, is \$10,000.

Senator HARKIN. How did they know that it was \$10,000?

Mr. BOOTH. Because they know the percentage that Medicare pays.

Senator HARKIN. Medicare pays a certain percentage of scholarships?

Mr. BOOTH. No; Medicare pays a certain percentage of total cost.

Senator HARKIN. All right. Let us try to see if we can figure this out, Mr. Booth.

Mr. BOOTH. OK.

Senator HARKIN. Are scholarships an allowable expense, under Medicare? You are saying, it may be, and it may not be.

Mr. BOOTH. Yes, sir.

Senator HARKIN. It depends on whoever looks at it.

Mr. BOOTH. Yes, sir; and it depends upon the total compensation package for the employees.

COST AUDITS

Senator HARKIN. And what guideline is there, for that?

Mr. BOOTH. The guideline is what other hospitals in the areas are paying for the same services. That is the determination that the intermediary makes when the intermediary audits these cost reports.

Senator HARKIN. And who would that intermediary be?

Mr. BOOTH. In the case of HCA, it is Blue Cross of Tennessee. And remember that these costs that GAO is talking about have not yet been audited, or were not audited when the GAO did its review. These are the costs that the HCA claimed. They are not necessarily the costs that the intermediary allowed.

Senator HARKIN. So now, let us get back. HCA put in for \$233,000 for scholarships for employees' children. Is that what they put in, to be reimbursed?

Mr. BOOTH. That is what they put on their cost report, as the total cost.

Senator HARKIN. As their total cost of what?

Mr. BOOTH. Of the scholarships.

Senator HARKIN. But they did not put that in, to be reimbursed by Medicare; they did not file that?

Mr. BOOTH. They did not expect to be paid \$233,000 by Medicare.

Senator HARKIN. I am not asking what they expected to be paid. Did they file that?

Mr. BOOTH. Yes, sir.

Senator HARKIN. They did?

Mr. BOOTH. Yes, sir.

MEDICARE SHARE OF OVERHEAD COSTS

Ms. WALTON. Let me try this. For hospital costs, Medicare pays for inpatient services using DRG's. So it is not a cost reimbursement. We pay a DRG amount: So much for an appendectomy, et cetera. For the outpatient costs, and a few other parts of hospitals, we actually settle on a cost report basis.

So, when a hospital files a cost report, they are putting down their entire cost for everything, soup to nuts. The portion they are looking at, for a Medicare reimbursement, is a very small portion. It is that portion of hospital costs that are Medicare, and are not DRG-based, and not fee schedule-based.

So it is really a pretty small part of the hospital's costs; \$10,000 worth of \$200,000 is like 5 percent. So, 4 or 5 percent of the hospital's payment from Medicare is going to come from their entire cost package. Because most of our payments now are under more of a fee schedule, with our DRG, et cetera. So that is why they know not very much of their moneys are going to come from—

Senator HARKIN. Because they know you are going to catch it in your audit, right?

Ms. WALTON. Well, no. Regardless of whether we caught it—

Senator HARKIN. And you do not catch it, you cannot catch it in your audit, because—

Ms. WALTON [continuing]. It is not a very large percentage that we settle under cost.

Ms. RUIZ. The point is that, the way cost reports are done, they are supposed to write down their total costs, understanding on both sides that Medicare only pays a percentage of their total operating costs.

Senator HARKIN. So therefore, the higher the amount you put in, the more money you get, right?

Ms. WALTON. That is true.

Senator HARKIN. That is not a bad deal.

Ms. WALTON. Yes; that is true.

Ms. RUIZ. But I think Mr. Booth's point is a simple one: That this was their total cost for that category and not what Medicare would pay, regardless of whether it is allowable or not allowable.

Senator HARKIN. Well, let us look at the other one here. How about the travel to Italy, Belgium, and Australia, \$53,657? How much of that did they put in, thinking that Medicare would reimburse them for?

MEDICARE SHARE OF OVERHEAD COSTS

Mr. BOOTH. Well, I am sure the trips were taken. HCA is an international company, and we have generally paid our proportion of their general and administrative costs.

We tried, in 1979, to separate out certain general and administrative costs; specifically, malpractice costs. Because we said, based on some studies that were done, that people who are Medicare beneficiaries generally do not have malpractice claims nearly so high as other people in the community. First of all, their life expectancy is somewhat shorter, and therefore, the awards would be less; and they are less likely to file claims.

We actually broke that out in a regulation that was duly promulgated. Most of the hospitals who had malpractice claims took us to court, and we virtually lost every case in court, trying to split out the malpractice area from general and administrative costs.

So we have now gone back to count this as general and administrative costs even though we think there are areas where we should share less than, perhaps, other payers.

There are other areas in general and administrative costs, where we share more than other payers. And so, the argument that the courts made is you pay more in some areas and less in other areas.

Specifically, with respect to the travel—and I do not mean to be an apologist for HCA—but they are an international corporation and as a result, we do pick up a small piece of their international operations, just as we pick up a piece of their president or CEO's salary that can be attributed to hospital operations.

We would have paid a very small portion, probably in the neighborhood of \$1,500, for this particular item.

Senator HARKIN. Well, I guess maybe I am a little disturbed by that now that I hear this. You say that it is an international company and some of their international travel you consider part of their administrative costs that you pick up. How about a flight to Italy to inspect a piece of sculpture?

Mr. BOOTH. Well, I would certainly say that is not allowable. But I would have to look at the specifics. It seems to me, on the face, that it is not allowable.

Senator HARKIN. I have got to tell you, Mr. Booth, from my standpoint I do not think any of their international travel ought to be allowed.

Mr. BOOTH. Well.

Senator HARKIN. I mean, that has nothing to do with—

Mr. BOOTH. I would agree. But in the malpractice area where we thought that some of those costs were not allowable also, we got beaten up pretty badly in court and we spent an awful lot of money in staff time and an awful lot of money in interest that we would not have paid had we never ventured into this area in the first place.

Our solution to this problem is very different than this. Our proposed solution to this problem is to get out of the reasonable cost business altogether and get all of outpatient services onto a fee schedule, so that we can begin paying on a fee schedule and not get into this auditing to the extent that we have over the last 27 years.

FAR AND OMB A-21

Senator HARKIN. Would you say, then, that we ought to go to something like FAR's and OMB A-21?

Mr. BOOTH. Well, we have looked at A-21 and we have looked at the Federal acquisition regulations. We are looking at them again. I must say that there are some similarities in spite of the contrasts that you have heard this morning. For example, under the definition of reasonable costs in Circular A-21, there is a specific reference to what a prudent buyer would pay for those services. That is one of the underlying principles in reasonable cost for that circular. It is also one of the underlying principles of reasonable cost under the Medicare principles, so we do have some similarities.

Second, the Circular A-21 allows a category of costs that we do not recognize, employee health, welfare, and morale costs, under which things like company picnics, for example, are allowable. We put those under fringe benefits so that we can look at the total compensation to the employee in relation to what other employees

are being paid in other facilities. So while there are some similarities, there clearly are some differences.

Now, you may note that in our written testimony we indicate that there are certain things that we do consider to be unallowable that the GAO and the IG have found. And we have committed in the written testimony to you today, sir, that we will change the provider reimbursement manual to reflect those clearly unallowable costs. We have also committed that we will review each and every one of the cost categories that the GAO and the IG have presented to you today and have presented in their reports, and clarify the manual with respect to whether or not we think those are allowable.

Senator HARKIN. Yes; in your written testimony you say we plan to make an in-depth analysis of the reports.

Mr. BOOTH. And we also say that—

Senator HARKIN. Has that been initiated?

Mr. BOOTH. Yes, sir.

PROVIDER REIMBURSEMENT MANUAL REVISIONS

Senator HARKIN. Based on our analysis of the OIG and the GAO's findings, we will revise the provider reimbursement manual to address specific categories of general and administrative and fringe benefit costs, in order to provide better guidance to hospitals, as well as all other providers and intermediaries, concerning the allowability of these costs. That is your written testimony.

Do we have any idea when that might be done?

Mr. BOOTH. Well, it is our plan on those that we clearly think are not allowable—the alcoholic beverages, for example, the contributions, the lobbying costs—we plan to put out a manual transmittal as quickly as we can get it cleared. It will probably take 60 days or so.

In some of the other areas, I think we need to look in somewhat more detail at both, particularly the individual IG reports, to determine what some of these expenses were. It is not clear, for example, why there were payments of \$4,000 or \$5,000 for flowers, for example. If that is a company policy because somebody is sick or because a member of the family died, I do not think that is necessarily unallowable if that is the policy of that particular company. Again, our participation in that would probably be in the \$250 range, even if we determined it is allowable.

But I think we need to determine precisely what was found. And, again, I would like to emphasize that none of these reports, particularly the IG's or the GAO, had been audited by the intermediaries. We are not looking—

Senator HARKIN. Say that again.

DATA USED BY GAO AND IG

Mr. BOOTH. These cost reports had not been audited by the intermediaries. These are the as submitted costs from the providers. So we are not looking at what the program paid, even if we took the percentages, because in many cases—take the FASB 106 issue with Massachusetts General Hospital—the intermediary is

clearly going to disallow that, and they are probably going to disallow the malpractice item with Humana.

Our policy on that is fairly clear. If the provider does not actually pay the money out, so that the money is out of the provider's control then no Medicare payment will be made. Apparently Massachusetts General Hospital has not actually committed that \$15 million in terms of a payment, so we are not going to make a payment. Only when they fund their retirees' health care costs would we participate to the extent that it would be the Medicare share.

Senator HARKIN. Mr. Booth, let me see if I understand what you are saying here. It is almost like you are implying that the GAO and the IG's office are raising a red herring here.

Mr. BOOTH. No; not at all, sir.

Senator HARKIN. Now, just a second. What you said was that they have done an audit on the cost reimbursement requests put in by Massachusetts General Hospital, but you said that clearly would not have been allowed anyway, that the intermediary would have picked that up and disallowed it anyway. So that is sort of a red herring, is sort of what you are saying.

Mr. BOOTH. I am not saying it is a red herring. I think the point that both the IG and the GAO were trying to make was that these are indicative of weaknesses in our manual procedures, and I agree with that. The hospitals are putting some things on their cost reports that they ought not to put on their cost reports. We are looking at that, and we are going to change the manual to clarify better what should or should not go on the cost report.

COST AUDITS

Senator HARKIN. I guess that is my point. And that is what I was getting to, is that in the absence of clear guidelines and specificity, how do we know whether the intermediary was going to pay that or not? We do not know. That is speculation on your part.

Mr. BOOTH. Well, I do not think it is speculation in the FASB area, because the policy is clear in the manual.

Senator HARKIN. But I have had examples of other policies that were clear, but they still put in for it anyway.

Mr. BOOTH. I think we all agree. Mr. Dowdal testified that the intermediary said it would not allow the \$15 million from Massachusetts General Hospital, so I do not think that is just speculation on my part. That item is too large, I think, to overlook. The \$15 million would have been picked up clearly in a desk review and would have been audited. Until Massachusetts General Hospital actually funds that, we are not going to participate in that. It is much less clear whether the intermediary would pick up the \$191,000 in advertising costs for the TV ads that I think are clearly unallowable.

RESPONSE TO IG REPORT

Senator HARKIN. Now, you have had this draft of the summary report of the IG's office that consolidated the findings from their 21 Medicare investigations. It has been at HCFA since July, 5 months ago. It is my understanding you have not yet responded to the IG's office. Is that correct?

Mr. BOOTH. That is correct. I believe the agency has not yet responded to the IG's report. That response is in final clearance, and I think it should be cleared sometime by the end of next week.

Senator HARKIN. What has the holdup been?

Mr. BOOTH. Well, one of the things is we wanted to wait for the GAO report. We wanted to see if we had confirmation of the IG's findings, because we knew GAO was doing a report on HCA. Similarities between the IG's findings and the GAO's findings, I think, prompt action on our part somewhat more rapidly.

Senator HARKIN. I thought that is what we had an IG's office for. That is what they are charged with. And if they make these findings and they submit them to you, you say well I am not going to act on them until I get a GAO study done.

Mr. BOOTH. No, no; we knew the GAO report was coming, and if we were going to change the policy, we wanted to try to change it once and not more than once.

GAO, IG, AND HCFA RELATIONSHIP

Senator HARKIN. But this is something, though—HCFA's been around a long time. I mean, don't you have internal procedures and processes yourself to catch these kinds of things? Or why do we have to have the IG and the GAO to come in and find this out?

Mr. BOOTH. Our procedures are based on the intermediary review of the cost reports and the intermediary audits.

Senator HARKIN. So you just rely on them.

Mr. BOOTH. We have to rely on them.

Senator HARKIN. You have no internal way of catching that yourself in HCFA, of disallowing these things, for example?

Mr. BOOTH. I only have ways of disallowing something or changing the manual when things are brought to our attention, such as the IG has done, that indicate that we are paying for things that we ought not to be paying for, or that hospitals are claiming things, as in this case, that they ought not to be claiming. We have begun work on reviewing the policies based on the IG report, and we have simply not gotten to the point of publishing revisions to the manuals.

Senator HARKIN. Maybe there is just something I do not understand here. It just seems to me like what you are saying is that HCFA pays all this money out to the intermediaries, and if no one raises a question you just keep paying it out, and then we have to get the IG's office to come in and do an investigation, or the GAO to do an investigation to uncover this, and then you will take action. I am shocked if you are telling me you have no internal mechanism at HCFA.

Mr. BOOTH. No; the agency—

Senator HARKIN. To uncover some of these questionable and obviously disallowable requests that come through.

Mr. BOOTH. No, no; we meet periodically. We meet every quarter with representatives from the fiscal intermediaries. In many of those meetings they tell us areas where they are having problems because of our instructions, because of the auditing they are doing or the desk reviews that they are doing. So we do have a mechanism to get information from the intermediaries.

The only point that I was trying to make is that we do not audit the cost reports ourselves. Those audits and those desk reviews are done for us by the fiscal intermediaries. They are our first line of defense, if you will, against these kinds of costs and these claims.

Ms. RUIZ. And if I could just supplement that, Mr. Harkin. Frequently our intermediaries do call to our attention areas that they think need some changes in policy. I also have to point out that we only have the ability to do in-depth audits on about 25 percent of our hospitals. We do, therefore, rely and ask for the help of the IG and the GAO to supplement what our intermediaries do in this percentage of audits and to help us find things.

I think the other important point I might make here is that the IG and the GAO have the ability to go in sooner than we do to look at these. As is evident from their reports, they were able to go in and look at the as-submitted cost reports at a much earlier time than we were because we have certain time lines for audits. We are in the process of auditing these hospitals now. It is entirely possible that in the process of audits that our intermediaries would disallow some of these things, identify other things and call them to our attention, but the IG was able to do that for us much quicker.

MEDICARE CONTRACTOR RATINGS

Senator HARKIN. GAO testified that you gave Medicare contractors the same ratings on their safeguard performance, despite large differences in the amount of money they are saving Medicare through those activities. In one instance, GAO cited the same grade being given to a contractor that saved Medicare three times as much per claim as another. Why?

Ms. WALTON. The ratings system or the evaluation system for contractors that HCFA sets out is to say what is acceptable performance and what is not; what makes someone a contractor we want to continue doing business with and what does not. The amount of money identified by any one contractor in a specific year is going to vary due to a lot of things. Sometimes a contractor may be working on a very large investigation which may not even come to conclusion in 1 year. There could, therefore, be large savings the following year.

The amount of moneys returned in one area are going to have a lot to do with the geography, the population, et cetera. It is hard to use whole dollars or cost-benefit ratios to label someone as good or bad. We try to lay out the expectations in a little broader terms: that they do thorough analysis and that they do follow up for educating the providers.

I guess the other thing is that the largest success for a Medicare contractor is not that they can either continually deny claims or mispay moneys and then recoup them. The largest success for the Medicare Program is if we can get a contractor to educate the provider community on what is the right thing to do, what are the appropriate things to put either on a cost report or on a Medicare claim, and how to file them correctly in the first place. After all, paying claims correctly the first time costs the public the least money. I continue to believe that the overwhelming number of pro-

viders, if we can get them clear information, do want to file claims right the first time.

Senator HARKIN. Well, I paid attention to that in your written statement, and you also verbally testified to that this morning.

Ms. WALTON. Yes.

PROVIDER EDUCATION

Senator HARKIN. I made a note on that. You stated, and I quote:

Therefore, the goal now is not to continue to deny inappropriate or medically unnecessary claims from a provider, but to educate the provider on what is and is not medically necessary and covered by Medicare, period.

In light of the appalling abuses that have been going on, as the inspector general and the GAO have just testified to, why would you want to deemphasize rejecting inappropriate claims in favor of educating providers? It seems to me the best education you can give someone is a sharp rap on the knuckles.

Ms. WALTON. Or even stronger for fraud, a little time in jail.

Senator HARKIN. Absolutely. But, again, I guess what I am bothered by is your deemphasizing that and saying the goal is now not to continue to deny inappropriate or medically unnecessary claims from a provider, but to educate them. I am saying wait a minute. I am all in favor of educating them, but that does not mean you lessen an aggressive, and I mean a fully aggressive, policy in going after these people.

Ms. WALTON. I think I am actually in total agreement with you on this. Let me see if I can explain myself a little more clearly. When we find a provider is doing something incorrectly, we certainly want the service denied or the claim denied. What I do not want to do is to have to fund either an intermediary or a carrier to find that same thing that they are sneaking in or doing wrong or misunderstanding year in and year out. I want to use the funds to move on and find other things.

When you find something that is being done incorrectly—for instance something here, you can explain very clearly to the hospital what is inappropriate and the way it should be done, or you can explain to the physician how Medicare rules work so they can change the way they are doing it.

For example, one of the examples that was given earlier was on some footcare where they did change behavior and save millions of dollars. Spending time denying similar claims from the same provider year in and year out, where it looks like you are getting a big bang for your buck, you just have not changed anyone's behavior. It is like you are teaching the same lesson over and over, and there might be a lot of other vulnerabilities that the budget has not even had time to consider.

Truly, I agree with you. I want to be able to spend the moneys on broader areas than the same things over and over.

FAR AND OMB A-21

Senator HARKIN. It seems to me that when you get to something like HCA, Hospital Corporation of America, that whatever you are doing in education does not seem to be educating them very much. This is big money a lot of money involved here, and, again, I get

back to the point that because of a lack of a clear delineation of what is allowable and not allowable, plus a vigorous enforcement; the two of those together add up to a lot of waste of taxpayers' money. And I think that is what GAO and the IG's office have found out.

Now, I do not mind education to get the manuals out and the information on what is allowable and what is not, but if we have kind of a hazy area in there about whether or not travel overseas is allowable depending upon whether you are an international corporation, people are going to take advantage of the biggest loophole they can find. That is human nature. And when it comes to Government payments, it is human nature magnified.

So it seems to me that we have to just draw the line on some of these. And that is why I am trying to get to the point of whether or not—you are looking at GAO's report and the IG's. Again, as it was testified to earlier, you have the authority, without us intervening legislatively, to adopt more stringent guidelines, whether it is an FAR or A-21. Or if there are some in there that are too lax, do not adopt those, use your own strict ones. So you can meld those together, right? You have the authority to do that?

Mr. BOOTH. Yes, sir; we do, and we are going to do it.

Senator HARKIN. Again, I ask when?

Mr. BOOTH. As I indicated, the first set will be out in approximately 60 days.

INCONSISTENT PAYMENTS

Senator HARKIN. I will look forward with anticipation to getting those, and to seeing how they are going to operate. We will have to consider inviting you back up here again in January, so we can take another look at it.

Well, there are just a lot of areas. I do not understand how HCFA is doing some of these things.

GAO testified that some of these contractors are paying as much as five times more for the same procedures as others. Why? How does HCFA do this? I mean, if it is the same procedure as others, how do you pay five times more? Do you have some standards that guard against this disparity, or what?

Mr. BOOTH. Well, I think you are talking about the laboratory testimony?

Senator HARKIN. Yes.

Mr. BOOTH. That came about as a result of the fee schedule that was passed by Congress in 1984. Under that fee schedule, which has been amended a number of times, Congress basically set forth the amounts that we were going to pay for virtually every lab test that was done on other than an inpatient basis.

Now, what Congress has done is lower the caps on that laboratory fee schedule in a number of different reconciliation bills. The latest of which was OBRA 93, in which the laboratory fee schedule caps will ultimately be reduced to 76 percent of the median to try to take account of an earlier Inspector General report which said we were paying more for laboratory services than others.

I do not think that will totally eliminate the disparities, but it will get the average laboratory payment a lot closer to what physicians are paying for those laboratory services.

Senator HARKIN. Why can we not just have a standard, a payment to labs? I mean, whatever they are charging physicians, that is all we are going to reimburse them for?

Mr. BOOTH. Well, there is some disparity there, because the way laboratories and physicians work together in billing—

Senator HARKIN. That is what I am concerned about.

Mr. BOOTH. That is actually a simplification—is not the same way that we work with laboratories. If an independent laboratory provides a test, the law requires—that the laboratory bill the Medicare Program, not the physician. This procedure resulted because we did not want the physicians marking up the lab service and getting the additional money.

It is somewhat more complicated for the laboratory to bill the Medicare Program, because they have to fill out a bill in every case.

So there is probably some disparity between those payments.

Senator HARKIN. Wait a second. A test comes in from a doctor to a laboratory. This test is not, it is not for a Medicare patient, OK? It is not a Medicare patient, it is somebody else. The same test comes in for a Medicare patient. It takes the same amount of time to do the test.

Mr. BOOTH. The test itself.

Senator HARKIN. The test itself, right. Now you are saying, for the one test that comes in from the doctor, they do not have to fill out some form or paperwork, but they do for Medicare?

Mr. BOOTH. Yes, sir.

Senator HARKIN. And that justifies five times as much?

Mr. BOOTH. No; that justifies a very small incremental difference in the payment. Nothing justifies five times the payment.

Senator HARKIN. Well, what would be the difference? I mean, I cannot see why they would even justify any difference at all. For example, if a lab is doing a lot of Medicare tests or tests for Medicare—and I am sure they all do, I mean, we know that. This is a big income for labs. It would seem to me that they have these forms down to a science. They put them into their computer, they punch a button, and out it comes.

Mr. BOOTH. But you have to put some information in the computer that you do not have to deal with the doctor on. You can just say, "Mrs. Jones, CBC, \$20." That is what the lab tells the physician.

The laboratory also has to give the name and address and the health insurance number of the patient, which means they have to get it, and they have to put it in their computer.

Senator HARKIN. But they get that automatically. That comes to the lab, I am sure, from whoever the doctor is referring patients to them.

Mr. BOOTH. Unfortunately, sometimes it does not come automatically, and the lab has to go get it. In these cases, there is an incremental cost. It is very small, but it is there.

LIMIT LAB REIMBURSEMENT

Senator HARKIN. I would wager you a bet, Mr. Booth. I will bet you that, if we put the limit that labs can charge at no more than whatever they reimburse their physicians for non-Medicare pa-

tients; I bet you would not see labs shutting down tomorrow. And I bet they would operate just fine; and they would be very happy with that.

I mean, again, if we are going to open it up and say, hey, listen, we know you have got to pick up the phone and call somebody once in a while, or, you've got to find somebody's address, and you have got this paperwork. We will allow you to have a 25-percent increase.

Mr. BOOTH. I would say, 50 cents a claim, at the most. But the lab industry will testify that labs will shut down. I would agree with you, that no lab would shut down as a result of that.

Senator HARKIN. I appreciate that. I do not think so, either, 50 cents a claim, I do not know; maybe that is what we ought to do. Just say, OK, you can charge no more than 50 cents more than what you charge a doctor.

Mr. BOOTH. That would still be a savings to the Medicare Program.

Senator HARKIN. I would think so.

HEALTH CARE REFORM

President Clinton's health care reform initiative proposes adding about \$150 billion in new Medicare benefits, providing coverage of prescription drugs and long-term care.

Once these new benefits are enacted, how much more will be needed for increased claims processing costs? How much more will be needed for payment safeguard activities? Again, if we are going to get into the whole area of drugs and stuff, we are going to have to have payment safeguard activities there for waste, fraud, and abuse.

And, if you couple that with a 5-year freeze in domestic discretionary funding, how are we going to be able to fund these new activities? Or can we do this out of the existing personnel and budget that you have? Will that be a great impact on HCFA?

Ms. WALTON. A new benefit, like a prescription drug program in Medicare and long-term care, could not be accomplished within our current administrative budget. I do not have with me estimates of what it would cost.

Senator HARKIN. Have you been asked that, by the administration?

Ms. WALTON. We have looked at that, and done some thinking about that. I can provide that to you, for the record.

Senator HARKIN. I would like to see what estimates you have come up with for the administrative, costs of these increased benefits.

MEDICARE CONTRACTOR PRIORITIES

Ms. WALTON. You know, anytime there is a budget squeeze on the administrative costs, it always becomes a real clear balancing act.

What I have learned is that you have to pay the claims first. If you do not pay the claims, it does not save you money, rather it costs you more money. Duplicate claims come in, then triplicate

claims. Phones ring. You have to keep a reasonable claims processing system going first.

The other thing I have learned is that you have to provide information to the providers and beneficiaries. You have to answer the questions; you have to answer the phones. And so, in balancing the budget, the discretionary funding becomes the payment safeguard areas.

We have made some really large progress toward keeping the cost of the claims processing very, very low; in fact, minimizing it so it allows as much money as possible for the payment safeguard areas.

PAYMENT SAFEGUARDS FUNDING

Senator HARKIN. Let me just finish with this question. I understand you have submitted your budget request to OMB for fiscal year 1995. Did your request include a proposal to fund increases in payment safeguards, at a level keeping pace with the growth in Medicare claims?

Ms. WALTON. In our fiscal year 1995 OMB submission, we requested \$388 million for the payment safeguards, which is the same as fiscal year 1994. Additionally, we requested an increase of \$28 million, to be funded in a similar manner as the Internal Revenue Service.

Senator HARKIN. So the 388 is a freeze from last year, or the same as last year. Again, Medicare claims are growing. And you hope to cover that with, you say, a \$28 million request that would basically be an off-budget \$28 million request?

Ms. WALTON. Right. We try to be more efficient with the claims processing, focusing the payment safeguards so we do not need to keep up dollar for dollar with the increasing number of claims.

The total amount of funds we can request is limited by the Budget Enforcement Act constraints.

Senator HARKIN. So the principle of what you are doing there with the \$28 million is really the same as what I have in my bill: To increase the safeguard activities?

Ms. WALTON. I expect so.

Senator HARKIN. Has OMB made any response to that yet?

Ms. WALTON. I am not aware of it; I think it is still being considered.

BUDGET SCORING

Senator HARKIN. I would like to close on this note, and I have had a running battle with OMB for some time on this. And that is that it is clearly demonstrable: Where we put \$1 out, we get \$14 in savings.

And again, this is not maybe types of savings. I mean, this is a real, hard dollar savings that we capture back.

And yet we get no scoring for that. We only get a scoring for the outlays of the \$388 million that we put out. And it seems to me, this is an odd way to run a budget. And so I am hopeful that OMB will respond to that, and let us get on with the payment safeguards program.

So I appreciate your being here today.

I am just told by staff that I should say also for the record, that any proposal to reinvent government, such as it is, ought to include this in it: The point is that, if you can show that an expenditure of taxpayers' dollars is actually saving money through auditing, inspections, et cetera, that that ought to be included in the scoring with OMB. It ought not to be just an expense, but it also ought to be an income to the taxpayers also. I am hopeful that will be included.

Let me just close by saying, I appreciate your being here. And I look forward to seeing your response to the GAO and IG's—well basically, the GAO report.

We might want to get together again after the first of the year sometime, to take another look at that, before I get into my appropriations cycle for next year.

Ms. WALTON. We would enjoy that. Thank you.

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

Senator HARKIN. There will be some additional questions which will be submitted for your response in the record.

[The following questions were not asked at the hearing, but were submitted to the Health Care Financing Administration for response to the hearing:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

HEALTH CARE FINANCING ADMINISTRATION

STAFFING CUTS

Mr. Harkin: Is it still HCFA's intent to undergo a major reorganization, with staff reductions of 10-15 percent a year, beginning next year? If so, how do you propose to have HCFA accomplish increased work loads resulting from Health Care Reform and a growing Medicare population, with decreased staffing levels?

Ms. Walton: The Health Care Financing Administration (HCFA) will achieve the mandatory reductions required by President Clinton's executive order regarding the streamlining of federal government. Since HCFA will be able to achieve these staffing reductions through attrition and a limited hiring policy, HCFA will not need to undergo a major reorganization or reduction in full-time permanent staff. The reorganization plan submitted by HCFA to the Department of Health and Human Services in October 1993 is an attempt to streamline our current business practices, improve efficiency, and allow HCFA to meet the needs of all of its customers.

HCFA expects to take an active role in Health Care Reform; however, the precise staffing needs resulting from Health Care Reform cannot be determined until a Health Care Reform proposal has been passed by Congress and signed by the President. Once Health Care Reform has been signed into law, HCFA will need to evaluate its staffing levels and identify specific staffing needs.

NEW MEDICARE BENEFITS

Mr. Harkin: Once the new benefits proposed in President Clinton's Health Care Reform initiative are enacted, how much more will be needed for increased claims processing costs? How much more will be needed for Payment Safeguard activities to adequately control waste, fraud and abuse?

Ms. Walton: We estimate that the new Medicare Drug Benefit under Health Care Reform will cost approximately \$1 billion per year to administer. The costs are as follows:

Ms. Walton: While President Clinton's Health Care Reform Plan was only recently introduced in Congress, the 2 benefits cited by Senator Harkin have

remained essentially the same since we began to make estimates in the Fall of this year. We have updated these estimates for this testimony.

PRESCRIPTION DRUG BENEFIT - Administrative Costs

CY 96	\$894 million
CY 97	\$944 million
CY 98	\$997 million
CY 99	\$1.05 billion
CY 00	\$1.107 billion

LONG TERM CARE

The Health Security Act includes funding for federal start-up and administration activities for fiscal years 1995-2000. There is no specific administrative budget for the new long term care program.

At this time, no final decisions have been made regarding which organization (or if there is a need for a new organization) within the Department will administer the program.

ADMINISTRATIVE COSTS:

CY '96	\$ 894 million
CY '97	\$ 944 million
CY '98	\$ 997 million

We will be happy to discuss our Payment Safeguard activities estimates with you as the legislation moves through the Congress.

Additionally, we are implementing the Medicare Transaction System (MTS). We believe efficiencies achieved by MTS will aid in the reduction of the overall cost to process claims in the Medicare environment and will provide reliable reports, which will facilitate HCFA oversight and management of the Payment Safeguard areas.

Mr. Harkin: With a 5-year "freeze" in domestic discretionary funding, how will we be able to fund the new benefits proposed in President Clinton's Health Care Reform initiative?

Ms. Walton: In order to assure proper spending, the Department is required to establish direct spending targets for entitlement growth through 1997. We anticipate that entitlement growth will remain within these targets and not require additional reductions in Medicare growth.

Adding long term care and a prescription drug benefit to our Health Care Reform proposal will provide necessary benefits in an efficient and effective manner that will serve both Medicare beneficiaries and others in need of special care and services.

Long term care will be financed by 3 sources: new funding, a federal share amount that is matched by state spending on home community based care, and general revenues. The estimated federal cost for long term care over 5 years is \$74.5 billion. After the year 2003, the formula used to determine the annual federal contribution for long term care will change.

Program costs for the new Medicare prescription drug benefit are estimated at \$66 billion over the next 5 fiscal years. Administrative costs are included in this figure. This total will be financed from general revenues, beneficiary premiums, and manufacturer rebates.

We estimate that general revenues will finance 64 percent of the program costs, beneficiary premiums will finance 22 percent, and manufacturer rebates will account for 14 percent.

CONSOLIDATION OF DURABLE MEDICAL EQUIPMENT BILL-PAYERS

Mr. Harkin: When will the consolidation of Durable Medical Equipment claims processors from 34 carriers to 4 regional "super-carriers" be completed?

Ms. Walton: The consolidation of claims processors is occurring according to a state by state transfer schedule. The last states are scheduled to transfer their claims to the regional carriers on March 1, 1994.

Mr. Harkin: Can you give specific examples of how the consolidation of Durable Medical Equipment claims processors should result in major reductions in unnecessary utilization of medical equipment?

Ms. Walton: Since the phase-in of medical equipment processing at the regional carriers only began in November, we do not have data to provide specific examples of how the consolidation will reduce unnecessary utilization of medical equipment. We will be happy to provide you with this information once the first reports are available, which we expect to be in the summer of 1994.

The consolidation of medical equipment claims processing at regional carriers allows for more focus on these claims. Although historically a small volume of total claims, durable medical equipment constitutes one of the largest volumes of medical necessity denials. To date, the regional carriers have established over 40 local medical review policies to address over 90 items of durable medical equipment. This will allow for more appropriate and consistent payment of medical equipment claims nationwide.

The initiative to consolidate medical equipment claims processing to 4 regional carriers also includes the development of a statistical analysis regional carrier. This statistical analysis carrier will perform ongoing review of medical equipment payments nationwide. It will provide information on medical equipment utilization and spending so that the regional carriers and HCFA can better monitor trends and identify aberrant practices.

Mr. Harkin: The consolidation of Durable Medical Equipment claims processors will cut down on unscrupulous suppliers "gaming" the Medicare reimbursement system, but it will not get at the issue of fee schedules established by law, which force Medicare to pay more than market price for certain types of equipment. What suggestions do you have to get at this problem?

Ms. Walton: In the past, we have asked Congress to amend section 1834(a)(10)(B) of the Social Security Act to give carriers the authority to apply inherent reasonableness and adjust payment allowances that they consider excessive. We believe that the current statutory requirements are so cumbersome that they impede any recourse to the inherent reasonableness authority. The Administration submitted a proposal to Congress in 1992 which gave carriers this authority, but this provision was deleted from the OBRA 1993 legislation.

DURABLE MEDICAL EQUIPMENT

Mr. Harkin: Have you reviewed Medicare's reimbursement policy for glucose monitors, hospital beds, intra-ocular lenses, and so-called "body jackets?" Do you agree that Medicare payments are excessive for glucose monitors, hospital beds, intra-ocular lenses, and so-called "body jackets?"

Ms. Walton: Medicare's reimbursement policy for glucose monitors, hospital beds, intra-ocular lenses, and body jackets are determined by the statute.

We are currently reviewing the payment amounts for glucose monitors and have decided to apply our inherent reasonableness authority if we determine that the payment amounts are excessive. Unfortunately, the process of applying the inherent reasonableness provision at the national level is lengthy and cumbersome.

We have not determined that payments for hospital beds are excessive.

Regarding Medicare payment for intra-ocular lenses (IOLs), a provision included in the OBRA 1993 recently enacted by Congress reduces the Medicare allowance for IOLs furnished in participating ambulatory surgical centers (ASCs). Beginning January 1, 1994, and continuing through December 31, 1998, the Medicare allowance for an IOL furnished by an ASC will be reduced from \$200 to \$150. This reduction will also affect Medicare payment for IOLs furnished in the hospital outpatient setting because the ASC payment is used, in part, to determine Medicare payment for ASC approved procedures performed on a hospital outpatient basis. In 1992, about 90 percent of the total IOL insertions (approximately 1.4 million) performed on Medicare beneficiaries were done in ASCs and the outpatient department of hospitals. We estimate that this payment reduction will save the Medicare program \$250 million over the next 5 years.

We have not determined that payments for body jackets are excessive.

Mr. Harkin: Is it practical to base Medicare reimbursement on actual costs of glucose monitors, hospital beds, intra-ocular lenses, and so-called "body-jackets," rather than the current system of providing inflationary adjustments to fee schedules that are already too high?

Ms. Walton: It is currently not practical to base reimbursement on actual costs since these figures are unavailable. We concur with GAO report HRD-92-22 dated November 6, 1991, in which the GAO reported that Durable Medical Equipment suppliers do not maintain records in a manner that permits direct computation of costs and profits by item.

CLAIMS TARGETED FOR REVIEW

Mr. Harkin: What percent of claims will be targeted for review in fiscal 1994?

Ms. Walton: On a prepayment basis, carriers are required to review 5 percent of total claims. On a post payment basis, carriers are to select and conduct comprehensive medical review on 3 per every 1,000 providers.

It is important to keep in mind that carriers are now using "focused" medical review when reviewing claims for medical necessity. Rather than reviewing every single claim that comes into the processing system, this "new" methodology allows carriers to target their efforts to those areas where it is apparent that a specific provider may be inappropriately billing (whether knowingly or not) for unnecessary services. Therefore, while it is true that carriers are reviewing fewer claims than last year, they are focusing their resources on those claims with a higher likelihood of being inappropriate.

Mr. Harkin: Ideally, what percent of claims should Medicare Contractors be reviewing each year?

Ms. Walton: We do not believe that there is an "optimal" level of claims review. Within our limited administrative resources, HCFA and its contractors have focused efforts on the most effective reviews. Some contractors have become quite proficient in "targeting" their review efforts. If more dollars were available, we would allocate those funds to the contractors able to achieve the highest reduction in program outlays, rather than arbitrarily increase the percentage of claims reviewed.

COMPARISON OF DURABLE MEDICAL EQUIPMENT COSTS UNDER PARTS A AND B OF MEDICARE

Mr. Harkin: Is there any evidence to suggest that hospitals pay less for Durable Medical Equipment under the Prospective Payment System than doctors and providers reimbursed under Part B of Medicare?

Ms. Walton: We are not aware of any studies conducted by HCFA, the OIG, or GAO which indicate that hospitals pay less under a Prospective Payment System than providers are reimbursed under Part B of Medicare.

LOBBYING PROHIBITIONS

Mr. Harkin: Even though you have announced that HCFA is now going to come up with Medicare regulations addressing lobbying, don't you think it would be a good idea for us to also amend the wording of the general provision to specify that any

recipients of appropriated funds are prohibited from using those funds to lobby? In other words, to expand the prohibition so that health care providers who are reimbursed by Medicare would also be covered.

Ms. Walton: The new provider reimbursement manual guidelines, which are currently being drafted, will prohibit all health care providers from reporting liquor, contributions, and lobbying as allowable on their Medicare cost reports. Let me emphasize that Medicare will not reimburse any health care provider for these costs because they are considered unallowable under the new guidelines.

MANAGEMENT WEAKNESSES

Mr. Harkin: Whose responsibility would it be to investigate the unusually high volume of claims for chiropractic services coming from similar areas served by different Medicare Contractors?

Ms. Walton: We expect individual carriers to investigate unusually high volumes of any type of claim in their service area and to take appropriate corrective action. Also, we provide national and state-by-state comparisons from information contained in the National Claims History (NCH) File. Carriers also request specific data from the NCH file.

Mr. Harkin: What is being done to improve management oversight of Medicare Contractors?

Ms. Walton: HCFA has taken a number of steps to improve its oversight of Medicare Contractors. We have begun by changing the way in which we conduct our oversight responsibilities. Too often, contractors focus only on those items contained in the Contractor Performance Evaluation Program (CPEP) -- often at the expense of other Medicare program requirements. The Contractor Performance Evaluation Program is only one of the factors now considered in the contract management action process. HCFA has expanded discussions on contractor performance to more actively include such important issues as:

- o Contractor costs
- o Results of special studies/reviews conducted during the year
- o Contractor performance as measured against Corrective Action Plans in force during the review year

- o General contractor management responsibilities, such as transition management and implementation of legislative changes
- o Results of physician and beneficiary surveys of satisfaction with contractor service
- o Performance improvement initiatives undertaken by contractors

HCFA routinely reviews the various workload data updates provided by contractors. We are looking for changes that have occurred from one reporting period to the next in order to identify possible problems.

HCFA also utilizes quarterly reports from our Regional Offices to identify contractors exhibiting performance problems.

AVERTING MEDICARE COSTS THROUGH OTHER CONTRACTOR ACTIVITIES

Mr. Harkin: What is HCFA's estimate of Medicare savings achieved by "front end" early detection and prevention activities, over and above the \$5.6 billion saved by Payment Safeguard activities?

Ms. Walton: We cannot specifically identify savings beyond those included in the \$5.6 billion. Payment Safeguard activities can be divided into three areas:

- o Recoupment activities (e.g. recovery of a MSP payment)
- o Cost-avoidance activities (e.g. the denial of a claim when Medicare is not the primary payer)
- o Preventive activities (e.g. beneficiary, physician and employer education about and awareness of Medicare coverage rules)

A major recoupment activity that HCFA is currently engaged in is the IRS/SSA/HCFA Data Match, an extensive effort to identify mistaken payments made by the Medicare program between the years 1983 to present (and continuing) and to secure repayment of all those monies.

An example of a Cost-avoidance initiative that HCFA is currently undertaking is the Initial Enrollment Questionnaire, which will be used by HCFA to obtain information from new enrollees on insurance

coverage. This information will allow HCFA to determine whether another insurance company should pay the bill before HCFA. The major benefit of this initiative is program savings.

It is very difficult to measure the monetary savings generated by preventive activities. For example, provider education about the Medicare Secondary Payer Program can result in a provider not submitting a claim to Medicare for primary payment and correctly submitting the claim to a private insurance company. This certainly does not mean, however, that preventive activities are not useful. While preventive activities contribute to a reduction in benefit payout, it is difficult to measure and assign a specific amount saved as a result of the activities.

MEDICARE CHARGES UNRELATED TO PATIENT CARE

Mr. Harkin: Does HCFA have any idea how widespread the practice of including activities unrelated to patient care in Medicare cost reports is throughout the 6,500 hospitals that participate in the Medicare program?

Ms. Walton: Based on our experience, we believe that the inclusion of costs for activities unrelated to patient care in Medicare cost reports is not significant and is not usually the reason for an adjustment.

Most of our major adjustments are in costs claimed that are related to patient care, but are not reimbursable by Medicare under HCFA regulations.

Medicare, through its Fiscal Intermediaries, audits approximately one-third of the hospital cost reports each year. There are usually extensive adjustments to the cost reports following an audit. Many times, the total costs claimed by the hospital on the cost report are determined to be not reimbursable. For example:

- o in the home health agency setting, a director may receive \$300,000 in annual compensation from his or her company. While this director's salary is undoubtedly related to patient care, Medicare may reduce the amount that the home health agency can claim on its cost report to a more reasonable figure. Our auditors determine the figure Medicare will accept by weighing a number of factors, including: the size of the home health

agency, the education and experience of the director, the geographic location of the agency, and the duties performed by the director.

- o a hospital may claim medical education costs based on its own count of interns and residents. However, the intern/resident count may be found by Medicare auditors to be significantly overstated, thus reducing the hospital's reimbursement.
- o a provider may allocate costs to high Medicare utilization cost centers. An audit may determine that the basis for allocation is inaccurate. While the costs are still related to patient care, Medicare's reimbursable share of such costs may be much less than submitted.

NEW DATA BANK

Mr. Harkin: Given the unlikelihood of any additional Federal funds becoming available for this purpose, how do you plan to implement the Data Bank as required by law?

Ms. Walton: HCFA and the Department, along with the Office of Management and Budget, are working together to comply with the law. This collaborative effort is necessary to meet the challenges associated with establishing a new, employee-specific, national data base.

In conjunction with the Department, HCFA is refining the cost and staffing estimates and an implementation schedule for this complex task. During the system design phase of the data bank effort, HCFA is endeavoring to minimize the burden to employers. To that end, HCFA will not impose employer penalties until after instructions are issued and employers have a reasonable time in which to comply. HCFA currently plans on issuing interim instructions by March 1, 1994.

As you know, funding for the data bank was not included in the FY 1994 HHS Appropriation. At this time, it is unclear whether HCFA's current level of funding can support an activity of this magnitude. HCFA's preliminary estimates of the data bank start-up and on-going costs are approximately \$17 million and \$25 million, respectively. HCFA is negotiating with the Department and the Office of Management and Budget about funding options.

Although the law provides for fees to be imposed on "users" (e.g. Medicare Contractors, State Agencies, employers), it is not clear who would be willing to pay for these data. Furthermore, in order to cover operating costs, the data bank user fees would likely be prohibitive.

We would be happy to discuss this matter further if you would like.

PROPOSED LEGISLATIVE SAVINGS

Mr. Harkin: What specifically is being proposed by the White House, based on recommendations of the National Performance Review, to save an estimated \$630 million by providing for increased flexibility and competitiveness in contracts with Medicare Contractors?

Ms. Walton: The National Performance Review includes a group of proposals designed to increase the government's flexibility in the management of the Medicare program. Currently, HCFA is severely constrained by special contracting rules which were developed at the inception of the Medicare program. Enactment of the proposals would allow HCFA to manage the Medicare program more effectively and provide for increased competition. These proposals include:

- o Amending the Secretary's contracting authority to allow for contracting with entities other than health insurance companies. Currently, the Secretary is required to administer Medicare Part B by contracting with health insuring organizations. The proposed change would open competition to whatever entity is best qualified to do the work. In many cases this might continue to be a health insurance company.
- o Eliminating the right of Part A providers to nominate organizations to serve as fiscal intermediaries. Since the start of the Medicare program, Part A providers, principally hospitals, have been allowed to nominate the fiscal intermediary (FI) they want to pay their bills. Once the original nomination is made, the ability to change FI's is limited. The statute requires that certain functions, such as determining the amount of payment, making the payment, or conducting audits be done by the FI. Eliminating the nomination process would allow HCFA to manage workloads more

effectively by assigning work to the FI's which perform well.

- o Amending HCFA's contracting authority to eliminate special carrier contracting authorities. This change would remove special provisions which constrain the Secretary from using standard government contracting procedures. For example, Medicare contracts can be terminated only after a lengthy hearing process. Also, Medicare carrier contracts are explicitly exempted from competition requirements.
- o Amending HCFA's contracting authority to eliminate the requirement for cost reimbursement contracting. Allowing for contracts that pay on an other-than-cost basis would give the Secretary greater flexibility to determine what contracting methodology would provide the best value for the government in a specific situation. Congress had previously allowed this authority through a provision which expired at the end of FY 1993. HCFA has used various incentive contracting provisions effectively in the last two years to reduce program payment errors, encourage electronic submission of claims and reduce cost.
- o Amending HCFA's contracting authority to eliminate the separate carrier responsible for railroad retirement beneficiary claims. Railroad retirement beneficiaries represent about 2.5 percent of the total annual Medicare claims volume. Maintaining a separate contract to administer Medicare Part B claims for entitled railroad retirees is duplicative and confusing to providers. These responsibilities should be folded into existing Medicare contracts. Since the local carrier follows the same rules as the separate RRB carrier does in processing claims, services to railroad retirement beneficiaries would be enhanced.
- o Revising regulations to permit HCFA to move functions among contractors. Current regulations impede HCFA's ability to contract in the most efficient and effective manner. The proposed revision would permit HCFA to move individual functions, such as medical review and provider audit, to a contractor able to provide the best value and service to beneficiaries.

The above NPR proposals are expected to produce savings of approximately \$30 million for FY 1994 - 1999. More importantly, they will allow for the implementation of the planned Medicare Transaction System.

A single Medicare Transaction System (MTS) will consolidate 14 processing systems to 1, enhance claims processing operations, and reduce administrative costs, resulting in a more uniform and better managed program. The Office of the Inspector General has concluded that HCFA would be able to achieve a significant reduction in claims processing costs through contractor consolidation combined with a MTS. In order to fully achieve the savings for the MTS, HCFA must be able to install the MTS software at the optimum number of sites to take advantage of economies of scale. The design contractor will recommend the exact number, but it will certainly be fewer than the current number of processing sites. Without the changes in legislation previously discussed, HCFA will be required to maintain much of the current contractor configuration and will lose most of the savings from the operation of the MTS.

The anticipated savings from MTS with contractor consolidation are estimated to be \$600 million for FY 1997 - 1999.

Mr. Harkin: How much of the projected savings are in discretionary spending, versus entitlement spending?

Ms. Walton: The total amount of \$630 million in savings will come from discretionary spending.

Mr. Harkin: Provide an itemized list of projected savings, for each of the next 5 fiscal years.

Ms. Walton: The total savings associated with the revised contracting authority proposals are \$30 million for FY 1994 - 1999 (\$5 million per year).

The total savings associated with the MTS initiative are \$600 million for FY 1997 - 1999 (\$200 million per year).

CONCLUSION OF HEARING

Senator HARKIN. Thank you very much. Thanks for being here. The subcommittee will stand in recess awaiting the call of the Chair.]

[Whereupon, at 11:10 a.m., Friday, November 12, the hearing was concluded and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

Material Submitted Subsequent to Conclusion of Hearing

[CLERK'S NOTE.—Additional material was received by the subcommittee subsequent to the conclusion of the hearing. The statements will be inserted in the record at this point.]

HOW TO HELP STOP MEDICARE FROM BEING RIPPED-OFF



I'm Bill the Pelican and I'm here to tell you about how to spot people who steal from Medicare and what you can do to stop the thieves.

Every year fraud costs Medicare \$\$\$ and you pay part of those costs. You pay higher taxes and more in coinsurance and deductibles to cover these Medicare losses.

Most providers of health care are honest business men and women who want to meet your health care needs. They understand that programs like Medicare rely on their honesty and good judgment. Medicare providers include:

hospitals, nursing homes, home health agencies, laboratories, end stage renal disease facilities, suppliers of home medical equipment, physicians, physical therapists - just to name a few.

When you receive items or services from these providers, they will bill Medicare for you. This "bill" is called a claim and it is sent for payment to one of the insurance companies that processes claims for Medicare.

A relatively small group of providers take advantage of you and the Medicare program. They often pretend to be helping you, but in fact, they're only helping themselves to Medicare money.

We have to work together to stop fraud.

CHAPTER 1

Medicare Fraud Is a Federal Crime!



In 1992, almost 800 million claims for Medicare benefits were submitted to Medicare for payment. Some of these claims were fraudulent. As fraudulent claims were detected, some providers were warned; some were fined; some were thrown out of the program; some were sent to prison. Despite our efforts, it is estimated that as much as \$10 billion was stolen from Medicare.

"When people steal from Medicare they steal from every one of us."

What is fraud? Fraud happens when someone knowingly and willfully lies in order to get paid. Fraud usually involves careful planning. It happens when a provider misrepresents on the claim form what was furnished. In other words, it's cheating.

We need your help to catch more of the cheaters. As the consumer, you can tell us whether you got the item or service as billed.



CHAPTER 2

Who Pays?

You pay! Costs to Medicare are used to figure the annual deductible and the amount of your monthly premium. Fraud causes these amounts to be higher than they need to be. Therefore, you pay more "out-of-your-pocket."

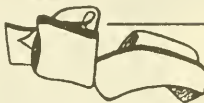
After you pay your monthly premium and the annual deductible, you still owe a share of the Medicare-approved amount for most supplies and services. This share is called coinsurance. Usually, your coinsurance share is 20 percent of the Medicare-approved amount.

If you receive an item or service that's not medically necessary, you or your private insurance company pay at least 20 percent of the cost of that item or service. Remember, private insurance premiums, like Medicare's, are based on the costs to these companies. The higher the costs, the higher the premiums.

So, as you can see, Medicare fraud causes you to pay more in insurance premiums, coinsurance and deductibles. We need to work together to stop fraud. Stopping the cheaters can save you money.

CHAPTER 3

Many Offices Must Work Together to Fight Fraud



The Health Care Financing Administration (HCFA) is the federal agency that runs the Medicare program. HCFA uses health insurance companies, such as Blue Cross and Blue Shield, The Travelers, and Aetna, to process bills for Medicare-covered items and services. Although these companies have their private business, the part of the company that processes Medicare claims is a separate operation.

The Medicare operations part of these companies ensures that the claims are paid correctly. These companies want to know about people who bill incorrectly or who furnish unreasonable or unnecessary services. The companies have Medicare fraud units whose job it is to catch people who steal from Medicare.

The Office of Inspector General (OIG), of the Department of Health and Human Services, is the law enforcement agency that investigates and prosecutes people who steal from Medicare. The OIG works closely with Medicare insurance companies, as well as with the FBI, Postal Inspection Service and other federal law enforcement agencies.

CHAPTER 4

What You Can Do

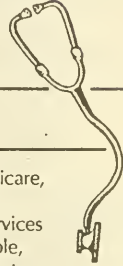
When you suspect that Medicare has improperly paid a claim, contact the insurance company that paid. The company will contact the provider to investigate. If you wish, your name will not be used. If you feel comfortable doing so, you may contact the provider that submitted the claim before calling Medicare. Inform the provider that Medicare paid for the item or service. Explain why you believe Medicare should not have paid.

If the provider made an honest mistake, it can be corrected and Medicare will get a refund. If the provider told you before you received the service that Medicare is not likely to pay for the service, you may have to pay for the service.

How do you know when Medicare has paid a claim on your behalf? Medicare will send you a form called an Explanation of Your Part B Medicare Benefits (EOMB). This notice explains what was billed; what Medicare paid; and what you owe. The EOMB also contains the name, address and telephone number of the Medicare claims processing company. Some have special "Fraud" hotlines which put you directly in touch with the fraud unit.

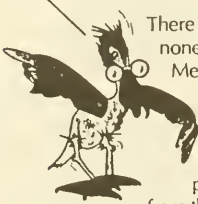
CHAPTER 5

The Most Common Rip-offs



- Billing for medically unnecessary items or services. Under Medicare, these are items or services that are not medically necessary to improve your condition. Medicare does not pay for items or services unless they are determined to be medically necessary, reasonable, and appropriate for treating your medical condition. Services that exceed your needs are not considered medically necessary. Medicare does not generally pay for preventive medicine, although there are a few exceptions.
- Lying to Medicare about your condition to get Medicare to pay for services.
- Performing services that exceed what is needed. Excessive diagnostic x-rays, clinical laboratory, consultative services, and unneeded home medical equipment are examples.
- Offering or accepting referral fees from another provider in exchange for referring you to them. These "fees" are considered "kickbacks."
 - Billing for ambulance services that Medicare does not cover. Medicare never pays for transportation from your home to a physician's office or to a dialysis center that is not at a hospital. If you, or a member of your family, have been transported by ambulance to a doctor's office for routine dialysis, and Medicare paid for the trip, it is possible that the reason for the trip was misrepresented on the claim. Report such billings.
 - Misrepresenting items and services on the claim form. The provider bills for an item or service which wasn't furnished or which differs from the service provided. For example, a physician bills for an initial visit but the visit was a follow-up. A podiatrist bills for foot surgery but only trimmed the toenails. A laboratory charges for blood tests, but no tests were done. A supplier delivers a basic wheelchair but actually bills for a more expensive model.

"When all is said and done, you pay higher premiums when people steal from Medicare. Each time Medicare pays a claim it shouldn't, the government is being ripped-off, and as a taxpayer so are you."



There are other violations that are not fraud, but which cost you nonetheless. For example, if your provider charges you for filing your Medicare claim, he or she is breaking the law. You should report it.

If you are billed for the 20 percent co-payment, although it was already paid by your private insurance company (often referred to as a supplemental insurer), you are being ripped off. If your private insurer pays after you paid the provider, request a refund from the provider.

When Should You Suspect a Rip-off?



Although most providers and suppliers are sincerely interested in your health, some are more interested in feathering their own nests. The following are practices you should look out for since they may indicate that you and Medicare are about to be ripped-off.

- Providers who advertise free testing or screening in exchange for your Medicare number. These providers may plan on billing Medicare without your knowledge. If the screening is truly “free,” they do not need your Medicare number. ***Never give out your Medicare number to people you don’t know.*** Treat your Medicare card like you would a credit card.
- Providers who present themselves as being a part of Medicare, the Health Care Financing Administration, the Department of Health and Human Services, the Social Security Administration or any other branch of the federal government. ***Neither the federal government nor Medicare endorses the products or services of any individual provider.*** Be suspicious of such providers. It’s OK for providers to say that they “participate” or are “certified” by Medicare to furnish services – if true.
- Any offer of free medical equipment. Many times the bills will contain false statements designed to get Medicare to pay. ***Only your physician can order medical equipment for you.***
- Any provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid. This provider may be telling you that he or she knows how to cheat Medicare. ***Don’t agree to let them do it.***
- A provider who uses pressure or scare tactics to sell you high priced medical services or diagnostic tests without giving you the opportunity for a second opinion. ***Unless it is an emergency, there is always time for a second opinion.***
- A provider who says that he or she will not require you to pay the 20 percent co-payments or deductibles without first investigating your ability to pay. For example, “It’s the doctor’s policy not to charge the Medicare co-payment.” Such offers may be offered as an incentive to get you to accept items or services you don’t need, or to influence your choice of a medical provider. ***Routine waiver of co-payments and deductibles is illegal.***

These are just some of the situations that may end up as fraudulent claims. There are many others. You need to be careful. Many times it is the patient who is stuck with thousands of dollars in health care bills for unneeded services.

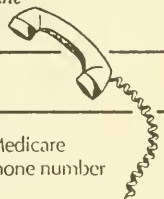
In many cases, you will not suspect foul play until you review the Explanation of Your Part B Medicare Benefits. These explanations include information on whether or not Medicare paid, how much, and the item/service for which Medicare paid. These statements are valuable in detecting Medicare fraud. Look for:

- Duplicate payment for the same service;
- Ambulance services you are not aware of;
- Payments for home medical equipment while you or a family member are in a Medicare approved hospital or nursing home;
- Dates of service on the EOMB that differ from the dates you actually received the service;
- Outpatient services billed while the patient was in the hospital; and
- Items or services you do not recall getting. Remember, however, that there are some instances when you will receive bills from a provider you never saw. For example, you may have gotten services from radiologists or cardiologists who interpret test results for your personal physician. You may never meet these consultants, but they perform real, necessary services.

"Help me stamp out Medicare fraud by reporting fraudulent activity to the proper office."

CHAPTER 7

How to Report Fraud



If you believe Medicare is being cheated, call or write the Medicare company that paid the claim. The name, address and telephone number are on the Explanation of Your Part B Medicare Benefits.

You do not have to give your name when you file a complaint. However, if you want to be informed of the results of the investigation, you will have to give your name, address and Medicare number.

Before contacting the Medicare claims processing company, carefully review the facts as you know them and as shown on the Explanation of Your Part B Medicare Benefits. Write down the:

1. Provider's name and any identifying number next to or below his or her name;
2. Item or service you are questioning;
3. Date on which the service is shown to have been furnished;
4. Amount approved and paid by Medicare;
5. Date of the explanation of Medicare benefits;
6. Name and Medicare number of the person who supposedly received the item or service; and
7. Reason you believe Medicare should not have paid.

If you plan to write rather than call, clearly state at the beginning of your letter that you are filing a fraud complaint. This will ensure that your complaint is processed through the mail room to the fraud unit. Address the envelope to the name and address on the explanation of Medicare benefits, attention: *Medicare Fraud Unit*.

CHAPTER 8

What You Should Expect from Your Medicare Carrier or Fiscal Intermediary When You File a Complaint with Medicare Alleging Fraud or Abuse

The receipt of your complaint will be acknowledged within 30 days. The fraud unit will give you a date by which they expect to complete their investigation of your complaint. If their investigation is not completed by the date promised, they'll notify you of their progress and expected completion date.

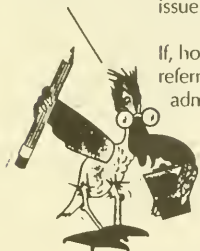
The fraud unit investigator will reach one of three conclusions and will notify you of his or her decision:

1. Although the claim may have appeared to be wrong, the provider correctly filed the claim. This is often the case with services billed by consultants and providers of diagnostic services such as clinical laboratories, radiologists, etc.
2. The provider made a billing error which appears to have been an honest mistake.
3. The provider appears to have filed a false claim.

"Medicare wants to know. File a complaint if you believe Medicare is getting ripped-off."

If the amount at issue is relatively small and there doesn't appear to be a pattern of fraudulent claims, Medicare will recover the overpayment and issue a warning to the provider.

If, however, the review discloses a pattern of fraud, the case will be referred to the Office of Inspector General for civil, criminal, and/or administrative action.



If you are told that the matter is being referred to the Office of Inspector General, the fraud unit is telling you that it agrees that fraud may exist and they are referring it for further criminal investigation.

"White collar" crime investigations often take a long time. Because of the complexity of these cases, the investigations may take many months, even years, to bring the wrong-doer to trial. Also, in certain instances involving very sensitive matters, it may not be possible to give out information during the course of the investigation.

CHAPTER 9

Penalties for Ripping-off Medicare



When a case is referred to the Office of Inspector General for investigation, the Office of Inspector General coordinates its investigation with several other federal and State law enforcement agencies.

Depending on the merits of the case, one or more of the following penalties may apply:



- **Criminal Prosecution** – It's a felony to steal from Medicare and some providers are sent to prison. People convicted are usually required to pay back what they stole, plus additional money in fines. People convicted are also barred from doing business with Medicare and Medicaid for a minimum of 5 years.
- **Civil Proceeding** – The U.S. Attorney may decide to file a civil suit or may decide that the interests of the program are best served by settling the case. In these cases, the amount stolen plus additional money is paid to the government in the form of penalties and fines. The penalties may include not being permitted to bill Medicare and Medicaid for a number of years.
- **Administrative** – Even when the U.S. Attorney's Office declines to prosecute the case, the Office of Inspector General may take action to exclude the provider. This means that for a certain number of years Medicare and Medicaid will not honor bills from the provider. If your doctor is excluded from Medicare, contact your Medicare carrier for the name of the closest participating physician that can meet your medical needs.

In addition to the penalties the Office of Inspector General and the U.S. Attorney's Office may impose, there are other administrative penalties available to Medicare, such as termination of their participation agreements.

Some providers, such as hospitals, nursing homes and home health agencies and some suppliers, such as clinical laboratories, end stage renal disease facilities and ambulatory surgery centers, must be approved by Medicare before they legally can be paid for Medicare-covered services.

If these providers and suppliers furnish bad or medically unnecessary care, physically or verbally abuse patients, or otherwise violate federal health and safety requirements, they may lose their approval to bill for Medicare and Medicaid services. Action to take away Medicare approval for these providers and suppliers is sometimes initiated by the Medicare Survey and Certification Agency, usually part of the State's Department of Health.

As the consumer, you are often in the best position to tell Medicare if you believe you are being ripped off. Medicare needs your help. They can't do it alone. It's your responsibility.

The people in HCFA, the Office of Inspector General, State agencies and law enforcement agencies across the United States are committed to stopping Medicare fraud and, indeed, all health care fraud and abuse.

If you would like someone from Medicare to talk to your group about Medicare fraud and what you can do to help stop it, contact the Medicare Fraud and Abuse Information Coordinator at your local Medicare insurance company. The company's name and telephone number are on the Explanation of Your Part B Medicare Benefits.

This publication was prepared by the Health Care Financing Administration, in cooperation with the Office of Inspector General of the U.S. Department of Health and Human Services.

